April 1999
Final Report

Review of the *Ambulance Services Act 1986*

Prepared by

The Allen Consulting Group

Foreword

Ambulance services are a major Government priority. Ambulance services are pivotal to the delivery of the State's health services and its emergency response capability, and the Victorian community expects that it will continue to receive high quality ambulance services.

Many people in the ambulance services industry are aware that the ***Ambulance Services Act 1986*** is currently under review, involving an independent review of restrictions on competition contained in the legislation, as required under National Competition Policy (NCP).

The Allen Consulting Group was engaged by the Department of Human Services to conduct the independent NCP review. It is one of many such legislative reviews being conducted in line with NCP requirements agreed by all Australian governments in 1995.

The Allen Consulting Group has now provided its report. The report follows extensive consultation with the industry, including release of a discussion paper in November 1998 and a series of stakeholder meetings, and has regard to a wide range of written submissions received in January 1999. The report has been considered by a broadly based consultative committee representing employees, employers and other key stakeholders in the ambulance services industry.

I wish to stress that the consultant's report is not a statement of Government policy, but represents independent advice to be considered by Government. As I have previously indicated publicly, however, important aspects of Government policy will not be changed. In particular, emergency ambulance services will not be privatised, and free pensioner ambulance transport will continue.

I have decided to release the report to the industry to promote further discussion of the consultant's proposals. Following that discussion phase, Government will prepare a response, expected to be released later in the year. It is anticipated that proposed legislative reforms will be introduced in the Autumn 2000 Sittings of Parliament.

This is a legislative review of key importance, taking place in conjunction with a number of other significant developments whose objective is to improve the provision of ambulance services in Victoria. Such initiatives include the amalgamation of rural ambulance services to form Rural Ambulance Victoria, development of a state-wide ambulance services clinical database, the First Responder pilot program, development of standards for non-emergency patient transport, and implementation of the Metropolitan Ambulance Service Emergency Operations Plan.

While I have identified key areas where Government policy will not change, the consultant's report and recommendations raise many issues which warrant further debate by industry stakeholders. I therefore urge you to participate in the consultation process and make submissions in response to the consultant's report. Submissions should be forwarded by close of business Thursday 1 July, 1999, to:

Mr Barry Nicholls
Director Corporate Strategy
Department of Human Services
12/555 Collins Street
MELBOURNE VIC 3000

Information about how to access further copies, and to make comment on the consultant's report, is set out on pages ii and iii.

The Government is keen to hear the full range of views in response to the independent report for the review of the ***Ambulance Services Act 1986***, prepared by *The Allen Consulting Group*. The main objective of the review of the legislation is to determine reforms aimed at enhancing the quality, responsiveness and efficiency of ambulance services, in order that the community continues to receive high quality services.

ROB KNOWLES
Minister for Health

HOW TO COMMENT ON THIS REPORT

Submissions in response to this report should be forwarded by close of business Thursday 1 July 1999 to:

Mr Barry Nicholls
Director, Corporate Strategy
Department of Human Services
12/555 Collins Street
MELBOURNE VIC 3000

Additional copies of the report can be obtained from:

Ambulance Services Branch
Corporate Strategy Division
Department of Human Services
4/555 Collins Street
MELBOURNE VIC 3000

Tel: 03 9616 7143; Fax: 03 9616 9888

The report can be accessed through the Department of Human Services internet site at this address:
http://www.dhs.vic.gov.au/ambulance

Readers are also encouraged to obtain copies of the Ambulance Services Act 1986, as amended by the Ambulance Services (Amendment) Act 1998. Copies are available from:

Information Victoria
365 Collins Street
MELBOURNE VIC 3000

Tel: 1300 366 356; Fax: 03 9603 9920.

The legislation can be accessed through the Department of Premier and Cabinet internet site at the following address:

http://www.dms.dpc.vic.gov.au

(0040499)

Suggested Response Format

If you are making a submission on behalf of an organisation, the submission should be endorsed by a member of the executive or management body of that organisation. If you are making a submission representing your personal views, it would be helpful if you provide your name and address, and an indication of your interest in ambulance services. All submissions will be treated as public unless respondents specifically request that they be kept confidential.

It is expected that many submissions will comment on a range of issues. To assist in analysis of responses, it is suggested that respondents provide a separate submission for each issue, or cluster of related issues, on which comment is being made.

FOR ORGANISATIONS

A. Cover sheet

Name:
Organisation:
Title/position held:
Postal address:

The attached submission represents the views of the organisation named above

Signed: Date:

B. Submission
1. Issue on which you wish to comment

2. Relevant section/pages of report

3. Comment

FOR INDIVIDUALS

A. Cover sheet

Name:
Postal address:
Interest in ambulance services: (for example 'subscriber', 'trainee ambulance officer', 'pensioner transport user')

Signed: Date:

B. Submission

1. Issue on which you wish to comment

2. Relevant section/pages of report

3. Comment

Contents

EXECUTIVE SUMMARY

Introduction

Ambulance Services are a crucial part of both the health sector and the State's emergency response capabilities. The Ambulance Services are currently government statutory bodies with an effective legislative monopoly on the delivery of emergency ambulance services.

The Allen Consulting Group was engaged by the Department of Human Services as the consultant to undertake an independent review of the *Ambulance Services Act 1986* (the Act), to advise on the case for reform of legislative restrictions on competition contained in the Act, and also to make recommendations on legislative reforms which will enhance the quality, responsiveness and efficiency of ambulance services.

A consultative process was undertaken including the release of a discussion paper, stakeholder meetings and written submissions.

Overview of Key Findings

The main issue tackled in this review was the application of competition policy to emergency ambulance services. Maintenance of public confidence in the State's ambulance services is critical. The overriding aim for Government must be to maintain a cohesive, integrated, high quality and equitable emergency response ambulance capability that is also efficient and effective. The principal focus of this review has been on what a best practice model for the delivery of emergency ambulance services might look like and to what degree within such a model is it possible to use competition to achieve the above outcomes.

After undertaking the review, it is The Allen Consulting Group's view that there remains a very strong justification for maintaining a single specialist statutory authority, at arm's length from government, with responsibility for efficiently, effectively and equitably purchasing ambulance services on behalf of the community, for coordinating emergency response through a monopoly central call taking and dispatch function and for maintaining the necessary high standards. The authority would generally control a single system of ambulance services and assure their delivery to high quality standards.

However, the consultant also found that there were a number of very good reasons why this statutory authority should not also be the actual provider of ambulance services. Structural separation of the service providers from the purchasing/regulatory function would:

- Provide a clear accountability for the specialist regulator/purchaser in balancing a range of public interest objectives to determine the most efficient and effective mix of ambulance services independent of a direct stake in ambulance operations.
- Provide the service providers with a much clearer focus on efficiency and service quality in operations and the management autonomy to achieve it.
- Open up the possibility of using competitive tendering and/or using multiple providers without raising competitive neutrality concerns about an in-house bidder.

Significant potential benefits were identified from the application of 'controlled' competition in emergency ambulance services. Under the proposed model, it is possible to gain the benefits of improved accountability, greater incentives for efficiency, service quality and competition without compromising the integrity of the overall service through maintaining strong central control over call taking and dispatch, through careful design of the regulatory and purchasing framework and through a phased approach to the development of industry and selective market testing.

Competition in Ambulance Services (Chapter 4)

The review began by examining the degree to which markets can be used to efficiently provide a range of ambulance services. From a competition policy perspective, the nature of the market is a critical factor in determining whether regulatory intervention is desirable for a given situation and, if so, what type of regulatory instrument is appropriate. Ambulance services should be seen as part of the broader market for medical transport and mobile medical services (see Figure 1).

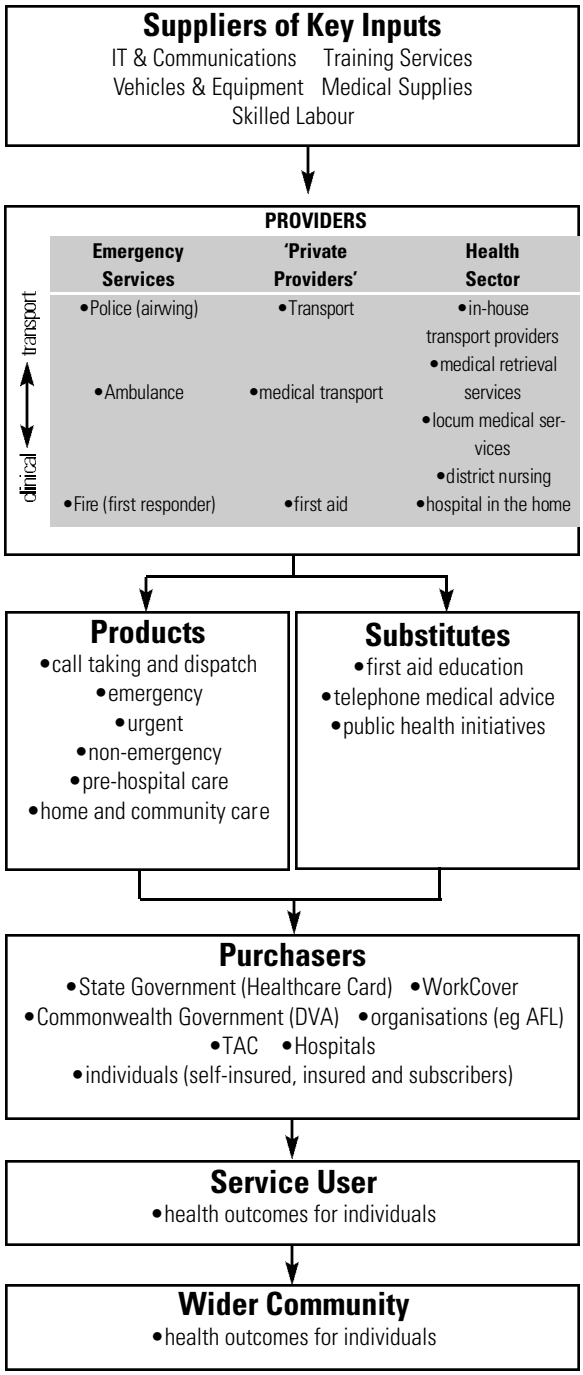
Call Taking and Dispatch (Section4.2)

Direct competition between emergency ambulance services, where ambulances compete to be the first to arrive at the scene, is clearly undesirable as it would potentially endanger lives and risk public health and safety. There continues to be a good justification for restricting access to calls made to the 000 emergency number; however, an independent, centralised call taking and dispatch function could facilitate indirect competition between emergency ambulance providers. (See Section 4.2 of the main body of the report).

Emergency (Section 4.3)

Emergency ambulance services in metropolitan areas are potentially contestable. Contestability may provide a range of benefits in terms of cost and efficiency, without compromising service quality, equity or public confidence objectives. 'Controlled' competition can and should be phased in for the metropolitan area, but only after the further development of standards, performance monitoring and measurement systems, contractual arrangements and a regulatory framework. As a prerequisite for competition, the emergency operations component of the Metropolitan Ambulance Service (MAS) should be structurally separated from its higher level functions — general control of the system, setting standards etc. The remaining core of MAS, combined with other elements from Rural Ambulance Victoria (RAV) and possibly the Department, should be constituted as an authority to perform the roles of specialist regulator/detailed purchaser for the industry. Chapter 5 discusses alternative structural models within which these basic directions of change could be implemented.

Figure 1 Overview of the supply of Medical Transport/Mobile Medical Services



Key differences exist between the rural and metropolitan markets for ambulance services. There are greater opportunities for economies of scale in service delivery in larger and more concentrated populations in metropolitan areas compared to smaller, more dispersed populations in rural areas. Therefore, introducing competition in rural emergency ambulance services is more

complex and less likely to result in clear benefits. Moreover, the sector is currently undergoing an amalgamation process. This is not to say competition in the provision of certain rural ambulance services may not be a possibility in the future. However, contestability opportunities should be pursued in rural and regional areas only after lessons have been learned from the initiatives in the metropolitan area. In the meantime, the real gains in rural and regional areas in the short to medium term appear to be from capturing the benefits of amalgamation. There is no contradiction in doing this whilst waiting to learn from the experiences of the proposed changes in the metropolitan areas.

Non-Emergency and Urgent (Sections 4.4 and 4.5)

The non–emergency market has always been subject to some degree of competition. A key question is whether there is a level playing field between ambulance services and private contractors. Ambulance services should be free to compete for urgent and non-emergency cases in the inter–hospital transfers market, so long as they conform to competitive neutrality pricing principles. In this context, regard needs to be had to the dependence of rural ambulance services on the non-emergency market to contribute to the infrastructure supporting their emergency role, but there is latitude in the pricing principles allowing that.

Subsidies for pensioner transport should be directly contestable by private providers and ambulance services. Hospital patient transport payment arrangements should be reviewed at the same time. To ensure that ambulance transports are not used for non–clinical reasons, improved guidelines should be developed in relation to the authorisation of subsidised pensioner transports. Consideration should also be given to the viability of other mechanisms to deter unnecessary usage. In relation to the issue of standards for the non-emergency industry, a single regulatory framework should apply to both emergency and non–emergency sectors. The regulation should not be overly prescriptive and should rely to the greatest extent possible on reference to industry–developed standards or codes of practice and existing quality assurance processes.

Pre-Hospital Care (Section 4.6)

The clinical capabilities and resources of ambulance services can clearly be used within the broader health sector especially in rural areas. The corporatisation of ambulance services would allow them to focus on core competencies and pursue additional activities that are complementary to their skills and resources. If ambulances are to be used to deliver mobile out–of–hours medical services, then they should be funded to do so or more effective alternatives considered.

Training (Section 4.7)

Training in the occupations required to deliver ambulance services should be managed under the same general framework as applies in broadly comparable areas, with the industry — and the regulatory authority for ambulance services — having a key role in setting standards. Ideally, such arrangements should be pursued at a national level with all major sections of the industry having representation. The Government would need to construct the future purchasing framework in such a way that necessary clinical experience is accessible to employees of all service providers.

Subscriptions (Section 4.8)

In a competitive environment, the combination of non–actuarially determined subscription rates and a seemingly strong 'brand' may provide a significant competitive advantage to the incumbent ambulance services in operating a subscription scheme. In the case of a move to a competitive environment, consideration should be given to the option of a single state–wide subscription covering public and private providers and overseen by an independent regulator/purchaser. Account needs to be taken of the commercial arrangements MAS has entered into for the running of the scheme; and of the implications of the Commonwealth's 30 per cent rebate on private health insurance (which may include ambulance cover).

There is also an issue surrounding the notion that, in addition to providing an insurance function, subscriptions represent a form of donation to a specific ambulance service. Although the insurance element can be easily be dealt with

under different competitive market structures, the donation factor is more difficult. The attractiveness of the subscription scheme may well be reduced if the ambulance service is made up of a range of different providers.

Emergency Management (Section 4.10)

Emergency management is a key role for ambulance services. The main concern for this review is whether emergency management objectives can effectively be met under a competitive model for emergency ambulance services. Emergency management objectives appear capable of being met through licensing and contractual mechanisms.

Alternative Structures (Chapter 5)

The review next examined a range of structural alternatives for the ambulance services industry against a set of public interest criteria. The focus is on emergency ambulance services since there is already substantial competition in relation to most of the other services. Six alternative structures were identified (see Figure 2). A description of and the key finding in relation to each model are provided below. (A more detailed discussion can be found in Section 5.2 of the main report.) The current structure of Rural Ambulance Victoria is most similar to Model 1 and MAS is probably best seen as a mixture of Models 2 and 6.

1. Single Statutory Authority accountable to Minister/Department—Operating under a specific legislative charter, a statutory authority balances a range of regulatory, purchaser and provider (business) objectives. The Authority is accountable to the Minister and the Department, whose roles include policy, high level regulation and high level purchasing.

- This traditional model of a government monopoly unnecessarily restricts competition and also raises performance and competitive neutrality concerns given the combined role of purchaser/regulator as well as provider—not recommended.

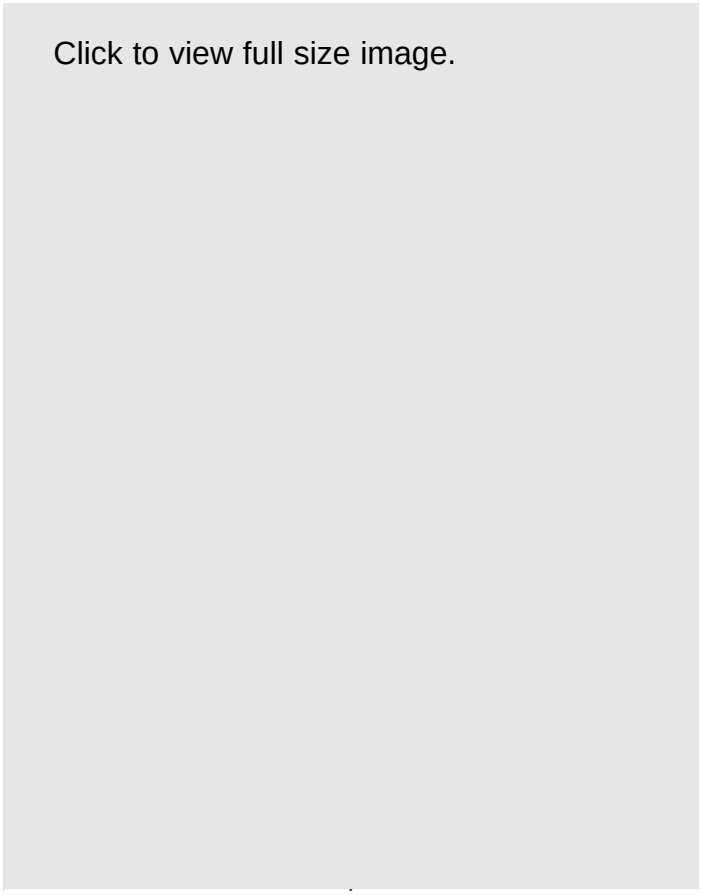
2. Statutory Authority with Ring–Fenced Business Unit accountable to Minister/Department—Similar to Model 1, except that the provider 'business' function is ring–fenced in a separate internal business unit, with a degree of management autonomy and with clear accounting separation.

- Suits the case where there are demonstrable advantages in having a regulatory function co-exist with a service provider function. However, this does not apply for ambulance services — not recommended. This model may nonetheless provide a useful transitional structure if on the way to one of the Models below.

3. Purchaser and Provider — a clear separation of the purchaser and regulator (these roles residing with the Minister and the Department) from a single service provider (a GBE or conceivably a non-government organisation). Appropriate advisory structures would provide for industry input.

- Improves on options 1 and 2 by providing a clear separation of the regulator/purchaser and provider roles, thereby promoting efficiency and providing a basis for competitive neutrality. However, this model lacks a specialist regulator and detailed purchaser at arm's length from government and also unnecessarily restricts competition by having a single dominant provider (with any competitors confined to niches)— not recommended.

Figure 2 Alternative Structures



4. Detailed Purchaser and Provider — This is similar to Model 3 in that there is a single major provider at the operational level. However, it introduces an additional layer of detailed purchaser and specialist regulator (setting standards, etc). These roles would be carried out by an independent statutory authority. The roles of Minister and Department are again restricted to policy, the high level regulatory framework and high level purchasing.

- An improvement on option 3 from the addition of an independent specialist regulator and detailed purchaser. It may be suited to those rural areas that can only support a single provider but in other areas, in particular the metropolitan area, competition may be unnecessarily restricted by limitation to a major single provider (with any competitors confined to niches). At present, a single rural ambulance service is, in fact, a good interim option — to allow the gains from the rural amalgamation process (greater consistency of practice, etc) to be consolidated before consideration of future options. A single metropolitan provider, perhaps with a number of relatively autonomous internal business units which could be independently benchmarked, could be an interim option for the metropolitan area. This model would be the case where a gradualist approach is preferred in moving to allowing a number of providers to share the delivery of the service. This would still be under a single authority, a single integrated area-wide call taking and dispatch system and a uniform system of service standards and quality assurance.

5. Multiple Geographic Franchises — A variant of Model 4 with multiple providers each of which is solely responsible for providing services in a specific geographic area.

- Strict boundaries, especially where they do not correspond to major 'natural' boundaries, are highly inefficient and can endanger patient outcomes — not recommended. However, if the boundaries are 'porous' (i.e. the unit best able to respond is always tasked regardless of boundaries) then Model 5 becomes similar to Model 6 below.

6. Unbundled Contracts — Essentially a more sophisticated variant of Model 4. Maintains a single, publicly-accountable, specialist government authority to purchase ambulance services in detail on behalf of the community — as the Health Care Networks do — and to set and enforce standards. This single authority could contract more than one major service provider (and possibly 3-6 providers of efficient operational scale in the metropolitan area, conceivably together with some niche operators). Under the terms of their contracts, service providers would generally operate from a loosely defined geographic base but could be tasked anywhere in line with system needs. In this way multiple providers would work as a seamless whole under the umbrella of centralised dispatch and a common system of standards and protocols and quality assurance. Patients and the public would not notice any material change to the quality of the service on the ground. A single emergency 000 number would remain, providers would use similar vehicles, equipment and livery, officers would have the same training and be subject to

the same basic set of operating protocols and standards, and pensioner concessions and subscriptions would continue. A single authority would control the system.

- This model provides for 'controlled competition' by allowing for the maximum expression of competition and efficiency within a tightly coordinated system, subject to effective regulation and sophisticated purchasing which ensures that service quality and equity concerns are properly addressed. Under this model, efficiency would be likely to improve and service quality would be at least maintained at the current level and would in time become significantly better. The model is, however, more difficult to implement than the other alternatives, and would require a phased approach utilising transitional structures and pilots. There would also be a differentiated approach between rural and metropolitan areas.

In summary, the consultant recommends that a future industry structure should, as a minimum, go to Model 4. However, the policy should allow for a possible transition to Model 6 if detailed business assessments demonstrate that a number of operational units of efficient scale would be capable of operating as independent provider businesses within the single system, with a high degree of assurance that service standards and quality would remain uniformly high or improve. The detail on the exact structure and timing of such a transition would be determined only after careful assessment in the earlier phases of the reforms. Model 2 would provide a useful structure within which potential new structures could be tested and developed prior to new legislation being enacted.

Complex industry structures cannot be implemented overnight. Any change to an industry structure will not be without risks, and these risks will need to be managed effectively during the transition. Therefore, in practice, it is likely that any changes will need to be phased in over a transitional period of a number of years to enable the necessary work to be done to ensure continuity of service and the maintenance of public confidence. The transition also needs to be carefully integrated with the pre-existing initiatives currently being undertaken by the DHS Ambulance Services Branch and MAS. Relevant initiatives being pursued by the Branch include the rural amalgamation process, the development of a state-wide ambulance services clinical database, the funding and pricing review, the implementation of the recommendations of the Non Emergency Patient Transport Taskforce and the review of the First Responder pilot program. The implementation by MAS of the Emergency Operations Plan is also relevant.

In parallel with the broad structural alternatives, there are clear opportunities for closer integration with other emergency services and the health sector. This could take a range of forms, including cooperation, co–location or complete integration. Such resource sharing possibilities are particularly important in rural areas.

There are many examples of existing community activities that support ambulance services, including volunteer officers or drivers, local auxiliaries and fund–raising activities. In planning for and undertaking the implementation of any different structural models for the provision of ambulance services, it is important that a strong emphasis is placed on maintaining community confidence and community engagement, especially in rural areas.

Regulatory and Purchasing Framework (Chapter 6)

The proposed regulatory and purchasing framework required to underpin the preferred model contains five main elements:

- *High Level Purchaser/Regulator* — the Minister and the Department to oversee the regulator/purchaser and to provide funding conditional on the regulator/purchaser meeting a range of requirements.
- *Specialist Regulator/Detailed Purchaser* — a statutory authority governed by an independent board, with a number of key responsibilities for the control of the system — including detailed purchasing of an effective, efficient and equitable mix of ambulance services for the community; call taking arrangements; overseeing the subscriptions scheme; price regulation; setting conditions on contracts; development and implementation of industry standards; establishing registration/licensing of ambulance services;

and coordination of emergency management planning.

- *Government Ambulance Services* — corporatised government business enterprises providing ambulance services on a commercial basis.
- *Registered/Licensed Ambulance Services* — allowing an ambulance service (public, private or not–for–profit) to use warning devices under certain circumstances and the term 'ambulance'.
- *Ambulance Officers Registration Board* — an independent, self–funding Board appointed by Government to administer occupational registration of ambulance officers for the purposes of public protection.

The current *Ambulance Services Act* contains significant restrictions on competition that are not justifiable on public interest grounds and the Act also does not support a best practice model for the provision of government services. The Act will require substantial change if it is to support the ambulance services of the future in a more complex and competitive environment. The new Act would be a sea change in ambulance services in Victoria and internationally. It would harness the best aspects of competition in a carefully regulated environment to provide the basis for significant improvements in the quality, responsiveness and efficiency of ambulance services in Victoria. It is a thoughtful and practical response to providing a best practice model for ambulance services of the future.

1. INTRODUCTION

Key Points

- The Allen Consulting Group was engaged by the Department of Human Services to undertake an independent review of the *Ambulance Services Act 1986* (the Act) and advise on the case for reform of legislative restrictions on competition contained in the Act.
- An important aspect of the review is to make recommendations on legislative reforms that will improve the quality, responsiveness and efficiency of ambulance services in Victoria.
- A consultative process was undertaken including the release of a discussion paper, stakeholder meetings and written submissions.

1.1 The Brief

The Allen Consulting Group has been engaged by the Department of Human Services to undertake a National Competition Policy review of the Ambulance Services Act 1986. The consultant's brief is provided in Box 1.1.

The review reported to the Minister for Health through a Steering Committee chaired by Mr Barry Nicholls, Director, Corporate Strategy, DHS. An Industry Consultative Council chaired by Mr Robert Doyle MP, Parliamentary Secretary to the Minister for Health, also reported to the Minister and provided advice to the Steering Committee. The reporting and consultative arrangements for the review were established in line with the requirements of the Victorian Government's National Competition Policy Guidelines. The terms of reference and membership of the Steering Committee and of the Industry Consultative Council were included in the Discussion Paper that was released in November 1998.

Subject to Cabinet approval, and in the light of other legislative priorities, a new Bill for the provision of ambulance services in Victoria will be put to Parliament in its Autumn 2000 sittings. The review is following the indicative timeframe as follows:

- Discussion paper released for comment: November 1998.
- Stakeholder consultation: November to December 1998.
- Responses to discussion paper: January 1999.
- Report and recommendations to the Minister for Health: March 1999.
- Discussions with industry and other government departments affected by legislative proposals: May to June 1999.
- Government response: September 1999.
- Bill to Parliament: Autumn sittings 2000.

It should be noted that the NCP review is only one component of the broader review of the Act, which also includes the separate issues of the amalgamation of the rural ambulance services and certain technical amendments, as addressed in Chapter 2.

Box 1.1: National Competition Policy Review — the Consultant's Brief

The consultant is required to examine the case for reform of legislative restrictions on competition contained in the Act, in accordance with the Victorian *Government's Guidelines for the Review of Legislative Restrictions on Competition*; and to make recommendations to the Steering Committee about legislative reforms which will enhance the quality, responsiveness and efficiency of ambulance services. In making such recommendations, the consultant will have regard to the objectives and terms of reference of the broader legislative review, and will seek to avoid undue inflexibility and prescription in future legislation.

In particular, the consultant will:

- Clarify the objectives of the legislation.
- Identify the nature of restrictions on competition imposed by the legislation.
- Analyse the likely effect of identified restrictions on competition on the Victorian economy.
- Assess and balance the costs and benefits to the Victorian community of any restrictions.
- Consider alternative means to achieve outcomes, including non legislative means.

Scope of NCP Review. The review will examine the appropriateness of specific provisions in the current legislation, and will more broadly consider barriers to market entry and competition in the context of contestability for state funded services.

Specific provisions of the Act to be addressed include:

- Powers to create, regulate, modify and abolish ambulance services.
- Powers to direct ambulance services.
- Powers to grant subsidies and to impose conditions.
- Requirement to obtain approval for capital expenditure.
- Powers to make and amend by-laws.
- Prohibition on use of the words 'ambulance' or 'ambulance service', or of insignia.

Broader issues to be explored by the NCP review include:

- Potential for contestability to improve ambulance service delivery in a range of health services markets.
- Opportunity for private providers to compete with government business enterprises.
- Competitive neutrality in relation to the range of benefits accessed by government business enterprises.
- Potential for competition in purchasing, as well as in provision, of ambulance services.

Such issues will be explored in context of emergency and non–emergency transport, output based funding, pensioner transport, membership subscription, and officer training and accreditation.

1.2 Government Objectives

What are the Government's objectives in relation to ambulances services?

The Act provides little guidance in this respect. Section 15 of the Act does provide a statement of the objectives of ambulance services (see Box 6.1 in Chapter 6). However, this defines the role of the services rather than the Government's broader objectives.

It should be noted that while the objectives of the legislation and for the ambulance services themselves are not explicit and detailed, such objectives need to be seen in the context of the overall public sector policy and management framework which, in a whole range of ways, emphasises accountability for the efficient and effective use of public resources.

The high level objectives in the human services area can be seen in the Department's primary goals, as stated in the 1998/99 DHS Departmental plan:

- Improve services for the most vulnerable sectors of the client population.
- Improve and maintain high quality services and facilities for clients.
- Strengthen population–wide interventions and outcome measurement to underpin sectoral strategies.
- Strengthen service integration to better tailor services to clients' needs.
- Achieve a more adequate mix and equitable distribution of human services.
- Drive further performance improvement in purchased and directly delivered services.

It is important to establish the Government's objectives so that options can be assessed against them (see Chapter 5).

1.3 Consultation Process

A consultation process involving a diverse range of stakeholders was a major component of the review. Prior to consultations, a discussion paper was sent to key stakeholders and made publicly available on the Department of Human Services internet site. Stakeholders were invited to provide submissions in response to the discussion paper. These submissions are treated as public except where respondents specifically requested that they be kept confidential.

In addition, stakeholder meetings were conducted with representatives of:

- Metropolitan Ambulance Service
- All rural ASVs (NE, NW, SE, SW, W, Alexandra and District)
- Department of Human Services
- employer association
- employee association
- non-emergency transport providers
- communications providers
- other emergency services
- training organisations
- consumer groups
- hospital emergency departments
- insurance organisations
- other government purchasers of ambulance services

For the sake of brevity and clarity, the approach that has been adopted in this report is to paraphrase stakeholder comments — rather than quote large tracts of text — drawing primarily on written submissions. Care has been taken to ensure that the views of stakeholders have been reflected as accurately as possible.

The following parties provided written submissions to the review (an asterisk [*] denotes those submitted on a confidential basis):

Alexandra & District Ambulance Service
Ambicare Patient Transfer
Ambikab Western Region
Ambulance Employees Australia – Victoria
Ambulance Officers Training Centre
Ambulance Service Victoria – North Eastern
Ambulance Service Victoria – North Western
Ambulance Service Victoria – South Eastern
Ambulance Service Victoria – South Western
Bail, Glen
Batchelor, Garry
CARER (Cranbourne) (*)
Colac Community Health Services
Department of Justice (see note 1)
Department of Veteran Affairs
Edwards, Michael
Epworth Hospital
Home Care Patient Transport
Inner & Eastern Health Care Network
Kingsley, Hugh

Metropolitan Ambulance Service
Medical Transport Service Aust Pty Ltd
Meditrans Patient Transport Pty Ltd (*)
Monash University
Mt Alexander Hospital
Nagle, Ian
Patient Transit Care Pty Ltd
Private Health Transport Operators' Assoc. (*)
Racing Victoria
Robertson, Glenn
Southern Health Care Network
St John Ambulance Australia (Vic)
St John of God Hospital, Ballarat
The Alfred Hospital
Till, John
Victorian Patient Transport Pty Ltd
Victorian Community Advisory Group on Mental Health
Wodonga Regional Health Service
Yarram Health Service

Note: 1. The submission from the Department of Justice included separate submissions from the Country Fire Authority, Metropolitan Fire and Emergencies Services Board, Victoria State Emergency Service and the Bureau of Emergency Services Telecommunications.

2. BACKGROUND AND CONTEXT

Key Points

- The overriding principles of National Competition Policy are that legislation should only restrict competition where there is a clear public benefit and that, fundamentally, government services should be provided by the most efficient service provider. Where a contestable market for government services exists, government providers should not enjoy a competitive advantage over non–government providers by virtue of their government ownership.
- Ambulance services in Victoria were legislated by the *Ambulance Services Act 1986*. The Act contains several sections that restrict competition in the market for ambulance services. Those restrictions are reviewed in this report in accordance with the Victorian Government's *Guidelines for the Review of Legislative Restrictions on Competition*.
- For the period of the review, ambulance services in Victoria were provided by the Metropolitan Ambulance Service (MAS), five major rural ambulance services (North Eastern, North Western, Western, South Eastern and South Western) and the Alexandra and District Ambulance Service. The five major rural services have now amalgamated to form Rural Ambulance Victoria (RAV). Emergency ambulance services are exclusively provided by these organisations. Some private ambulance companies provide non–emergency transport services.
- Ambulance services are part of a broader health system which is characterised by a range of complex policy and regulatory issues and which has been subject to a range of reform measures.
- Ambulance services are also part of the State's broader emergency response efforts and share many similar characteristics with other emergency services, such as fire and police services. There are significant opportunities for integration between the services.
- There is a multitude of models for the funding and provision of ambulance services around the world with a mix of government and non–government service provision. A clear distinction is generally made between emergency and non–emergency transport services, with non–emergency services being contestable in many jurisdictions.
- Recent changes in a number of States and Territories in Australia are resulting in a greater emphasis being placed on making ambulance services potentially more contestable, usually by giving the relevant Minister the authority to choose the most appropriate provider.

2.1 Context of the Review

National Competition Policy

Over the last decade, micro–economic reform has been a key thrust of Australian governments. Following Commonwealth Government tariff reforms, for example, which exposed Australia's domestic manufacturing industry to greater international competition, pressure has grown for more effective competition within Australia. It quickly became apparent, however, that many of the major benefits to be gained from micro–economic reform lay within State jurisdictions, and that a national approach was needed.

The inaugural Council of Australian Governments (COAG) meeting commissioned the 'Hilmer Committee' to conduct an inquiry into the development of a national competition policy. The Hilmer Report was presented to COAG in August 1993, and formed a major input to micro–economic reform discussions for COAG. The reform agenda recommended by the Hilmer Committee was based on six principles:

- Limiting anti–competitive conduct.
- Reforming regulation that unjustifiably restricts competition.
- Reforming the structure of public monopolies to facilitate competition.
- Providing third party access to facilities that are essential to competition.

- Restraining monopoly pricing behaviour.
- Fostering 'competitive neutrality' between government and private business when they compete.

A nationally coordinated micro–reform program has since been negotiated. The program includes payment of major financial grants by the Commonwealth to the States being made conditional upon the achievement of micro–economic reform targets in a range of sectors; and agreement to review, by the year 2000, all legislation which restricts competition.

In April 1995, the Commonwealth, States and Territories agreed to the implementation of the National Competition Policy (NCP). As part of that agreement, all governments have agreed to review existing legislation against the guiding legislative principle that:

> *'Legislation should not restrict competition unless it can be demonstrated that: the benefits of the restriction to the community as a whole outweigh the costs; and the objectives of the legislation can only be achieved by restricting competition.'*

This principle is intended to establish whether particular restrictions on competition remain necessary, through an assessment of the costs and benefits of current and alternative means of achieving policy objectives. The burden of proof is on governments to establish a public interest case for the retention or enactment of legislation that has the effect of restricting competition.

Clause 5(9) of the *Competition Principles Agreement* has been given the force of law in Victoria through the *Subordinate Legislation Act 1994* (10(1)). Under these provisions, it is required that the NCP review should:

- Clarify the objectives of the legislation.
- Identify the nature of any restrictions on competition.
- Analyse the likely impacts of the restriction on competition in the industry as well as on the economy more generally.
- Assess and balance the costs and benefits of the restrictions.
- Consider alternative means of achieving the same result, including non legislative approaches.

The legislation governing ambulance services in Victoria contains restrictions on competition, and is therefore required to be reviewed in accordance with the Victorian Government's *Guidelines for the Review of Legislative Restrictions on Competition*. The NCP review examines the case for reform of legislative restrictions on competition contained in the Act, and makes recommendations about legislative reforms aimed at enhancing the quality, responsiveness and efficiency of ambulance services.

Under the Government's guidelines, NCP review of the Act is classified as 'Level 2', requiring reviewers to be 'independent of the affected industry, and not engaged in the business or regulatory activity under review'. Following a competitive tendering process, *The Allen Consulting Group* was engaged to conduct the NCP review.

The NCP review examines the appropriateness of specific provisions in current legislation, and more broadly considers barriers to market entry and competition in the context of contestability for state funded services. Such issues are explored in the context of emergency and non emergency transport, output based funding, pensioner transport, membership subscription, and officer training and accreditation.

Amalgamation of Rural Ambulance Services

Five of the previous six rural ambulance services have recently amalgamated to form one rural service formally known as Rural Ambulance Victoria (RAV). The sixth service, Alexandra and District Ambulance Service, operates within a limited geographic area, is staffed almost entirely by volunteers, and is not proposed for inclusion in the amalgamation. RAV assumed management responsibility for ambulance service provision in March 1999.

The process for amalgamation of rural ambulance services itself involved extensive consultation processes. Therefore, except where issues of contestability are raised, matters relating to the amalgamation are not addressed in this report.

It is intended that legislative proposals to underpin RAV will be included in the Bill proposed for introduction in the Autumn 2000 session of Parliament.

It should be noted that legislative proposals will also need to address issues in relation to the Alexandra and District Ambulance Service, which is currently subject to separate legislative provisions regarding a range of matters. As noted above, it is not proposed that the Alexandra Service be incorporated in the reorganised rural management arrangements, although this would be possible were the Alexandra Service to so elect. The proposed legislation will need to provide flexibility in this respect.

Technical Amendments

After almost twelve years of operation, a range of technical and other matters in the Act need examination to ensure that future legislation is not overly prescriptive, and that non legislative means are pursued where appropriate. Such matters include the nature of the relationship between DHS and ambulance services. The review considers the nature of authorities of the Secretary of the Department, in context of an appropriate interface with services.

A number of other areas will also be examined, including the legislative basis for health services agreements between the Department and ambulance services; provisions for the making of by–laws; development of state–wide clinical standards; administration of medication by ambulance officers; and requirements for maintenance and provision of records regarding patient care, in light of proposed Victorian privacy legislation. Clearly, many such matters interface with issues of contestability and, as a consequence, are addressed in Chapter 4 of this report.

2.2 The Health Sector

The Need for Government Regulation in Health Care Markets

In its *National Competition Policy Guidelines*, the Victorian Government recognises that competitive markets generally promote the welfare of the community by encouraging efficient resource flows, low cost production and technological innovation.

However, it is also recognised that competitive markets can sometimes fail to deliver these desired outcomes. This can arise for a variety of reasons. Some goods and services – such as street lighting, lighthouses and public radio – are accessible by *all* consumers, so that charging users on an individual basis is not feasible, and can result in inadequate provision if left in the hands of the private sector. Economists refer to such goods as 'public goods', and their provision tends to be funded by government.

Markets fail in other ways – for example, where firms and people are not accountable for the external consequences of their actions. Polluting factories, for instance, impose a burden on the community for which the factories may not pay. In some industries, it may be wasteful to have competition because of the high costs of duplicating certain infrastructure (such as railway lines or gas pipelines). Competitive markets can also fail as a result of information failures where, for example, sellers have more information about product quality than buyers, or *vice versa*.

The markets for health services are often said to fail in one or more of these ways, and market failure has been one of the reasons for the considerable involvement of governments in the delivery of health services. Since ambulance services are an important part of the wider health system, it is useful to view the issues first for that wider system.

One of the principal market failures associated with health services generally concerns information failures, which is related to problems of health insurance. Even where there is a 'free' public health care alternative, uncertainty and the often high costs of future health care create a demand for health insurance. Once this insurance cover is in place, however, problems of the *over–utilisation* of medical care can result. On the demand side, this is reflected in the amount of covered care that is taken up – because insured patients are not responsible for paying the full cost of being treated. On the supply side, the incentive to over–provide medical services may be increased when a third party is paying the bulk of any services that doctors choose to supply. The problem can be deepened by the genuine ethical concerns of doctors to supply the best possible care for their patients, with little consideration given to cost.

Apart from market failure in private health care markets, other reasons have been put forward for the high level of government involvement in the delivery of health care. For example, the public provision of health care helps to contain the spread of communicable diseases, which clearly has benefits for society as a whole. However, this accounts for only a small proportion of health expenditure. More broadly, health care is regarded as an essential service that should be available to all members of society, regardless of their ability to pay. Economists sometimes refer to health care as a 'merit' good. Merit goods (or services) may be provided or subsidised by the state on the grounds that individuals 'ought' to consume them, but would not act in their own self interest and purchase an adequate amount of the good (or service) without substantial subsidisation.

Possible Approaches

Although health care markets do not work perfectly, it is still possible to improve efficiency in the way health services are provided. In some cases, this can include the increased use of price signals and competitive mechanisms. Many countries have adopted reforms in recent years aimed at improving the efficiency of their health care systems. These have included, amongst others:

- Strengthening the role of purchasers, whether public authorities or private insurers (for example, by choosing contracting arrangements with providers with a view to controlling overall costs).
- Empowering funders to be more effective purchasing agents for health consumers.
- More competition and improved pricing behaviour in the hospital sector. (For example, in the UK, funders are no longer restricted to purchase from local hospitals, whilst in Denmark and Sweden, consumers now have free choice over the hospitals where they seek treatment – this encourages providers to compete on price and quality.)
- Making parts of the public system contestable by private providers or contractors (for example, the provision or operation of certain facilities and services).
- Better contracting methods, so that prices are brought more closely into line with costs; performance indicators (such as quality, quantity and cost dimensions of services) can be specified and monitored; and risks can be shared (for example, with payments related to outputs under case–mix systems using Diagnosis Related Groups or similar approaches).
- Greater autonomy for hospital decision making (for example, allowing individual institutions to negotiate directly with staff over pay and conditions, rather than being bound by centralised agreements).
- Through competing mini–integrated systems, such as preferred provider organisation arrangements, where the insurer contracts with suppliers at preferential rates. Patients can choose other providers but are obliged to cover the difference in cost.

Recent Changes in the Victorian Health Sector

This review of the Act is occurring in the context of the nationally coordinated micro–economic reform program agreed to by all Australian governments. The Victorian Government has been at the fore in embracing the principles underpinning National Competition Policy, and approximately 400 pieces of legislation in the State are due to be reviewed by the year 2000.

In addition to the Act, many other pieces of legislation relating to the provision of health care services in Victoria are being reviewed. Already, the Victorian health care system has undergone substantial reform over the past five years or so. It is useful when considering any future reform of the way in which ambulance services are provided to consider the general thrust of the reforms that have already taken place in the broader health sector. These can be summarised as follows:

- A shift towards a purchaser/provider split in the public health care system, with the DHS increasingly taking the role of a purchaser of acute and non–acute services. This approach has facilitated greater accountability for operational performance, and has developed the tool to develop commercial arrangements with the private sector for the provision of public patient services.
- An increasing focus on output–based service contracts and the introduction of a case–mix purchasing policy (ie, where funding is related

to the average unit cost of treating a case).

- The pursuit of a policy of generally increasing contestability in the health sector, with many public hospitals contracting with the private sector for the provision of significant clinical and non–clinical services (including, for example, the provision of non–emergency ambulance transport). Indeed, more than a quarter of metropolitan public hospital throughput and around 15 per cent of rural hospital throughput is now flagged for contestability.
- The use of private sector investment for a number of major hospital developments, with the Government retaining responsibility for funding the care provided within them. The new Latrobe Regional Hospital has been financed and will be operated by the private sector, through an innovative performance–based contract. Private sector investment is also being sought for new hospitals for treatment of public patients to be developed at Mildura, Knox and Berwick, and the Austin and Repatriation Medical Centre.
- There has been a focus on service planning and reduction in duplication of capital and services. A number of hospitals have been closed or undergone a change in service emphasis. There have been amalgamations of a number of regional and rural hospitals, as well as aged and community health services. Meanwhile, as discussed in Section 2.1 of this report, the five major rural ambulance services are scheduled for an amalgamated structure in March 1999.

2.3 Emergency Services

Emergency Service Organisations in Victoria

In addition to Ambulance Service — Victoria, the other emergency service organisations that exist in Victoria are:

- *Victoria Police* —The core business of Victoria Police is the provision of a 24 hour police service to the community. About 20 per cent of police work is directly related to the role of fighting crime. The larger part of the workload involves "general policing" and assisting the community.
- *Metropolitan Fire and Emergency Services Board (MFESB)* — Formerly the Melbourne Fire Brigade Board, the MFESB is responsible for fire suppression and prevention (along with responding to other forms of emergencies) within the Metropolitan Fire District.
- *Country Fire Authority (CFA)* — The CFA is one of the world's largest volunteer emergency services, with around 70,000 volunteers. It operates in rural areas, in the provincial centres and in outer Melbourne Metropolitan suburbs. Although its main role is in firefighting, it also responds to other types of emergencies, such as road accidents and chemical spills.
- *Victoria State Emergency Service (VICSES)* — The VICSES plays a key role in countering the effects of natural and technological emergencies. Its network of approximately 5,500 volunteers is backed up by a team of paid emergency management professionals. In addition to providing a supporting role to the other emergency services, as required, the VICSES responds to emergencies such as flooding, storms, earthquake, road accidents and search and rescue. It also assists municipal councils and other agencies with the provision of advice, information, education and training in relation to emergency management, which includes prevention of, response to, and recovery from emergencies.

Whereas ambulance services in Victoria are currently the responsibility of the Minister for Health within the Department of Human Services, the other emergency service organisations listed above fall under the auspices of the Minister for Police and Emergency Services within the Department of Justice. The legislation under which these emergency service organisations operate has not been subject to a National Competition Policy review.

Synergies and Integration Between Emergency Services

Given the significant similarities in operational style between the different emergency services, overlaps sometimes exist between the services, and there are opportunities for integration that can result in often sizeable cost savings. Resource sharing possibilities are particularly important in rural areas where economies of scale can mean that stand–alone services can be expensive and under–utilised. Nevertheless, opportunities also exist within the metropolitan area. These issues

will be introduced in the following paragraphs, and explored in more detail in subsequent sections of this report.

One area where integration between the different emergency services is particularly well advanced is in communications. Until late 1995, each emergency service organisation in Victoria had developed and implemented an individual call taking and dispatch system, engineered to serve its own individual requirements, within its own communication centre and operated by its own service personnel. However, following a review of the then Metropolitan Fire Brigade Board in February 1993, it was recommended that a multi–agency system be implemented. The following year, the Victorian Government established a Ministerial Steering Committee supported by a unit within the Department of Justice, known collectively as the Bureau of Emergency Services Telecommunications (BEST). Responsibility was assigned to BEST for the development and implementation of a shared computerised call taking and dispatch service for Victoria's emergency service organisations.

Another source of cost savings is through the co–location of infrastructure facilities. For example, there are already a number of sites in Victoria where the co–location of fire and ambulance equipment occurs, and further co–locations are planned.

Experience from overseas demonstrates that there are possibilities for integration in service. In the US, for example, a number of fire services also provide ambulance services, and this concept is now being tested in Victoria in the form of the "First Responder" Program in the eastern and south–eastern suburbs of Melbourne. Under the pilot program, MFESB officers have been trained in the use of semi–automatic defibrillators, and are simultaneously dispatched with MAS units to cases where there is a high probability of cardiac arrest. The aim of the program is to test whether this approach can improve the time to defibrillation for cardiac arrest patients, and improve patient outcomes in these very time–sensitive cases. It is understood that the VICSES is keen to explore a similar first responder cooperative arrangement in rural Victoria.

Another area in which the various emergency service organisations in Victoria cooperate is in emergency management planning. Emergency management involves the plans, structures and arrangements that are established to bring together government, voluntary and private agencies in a comprehensive and coordinated way to deal with the whole spectrum of emergency needs, including prevention, response and recovery. Victoria's history has been punctuated with a range of emergency situations (some of them highly destructive) and the State has developed a capability for dealing with such events. A state emergency response plan (originally known as DISPLAN) exists for the coordinated response to emergencies by all relevant agencies. The emergency service organisations (along with other community organisations) play an integral role in emergency planning, which is designed to ensure that the activities of the various emergency organisations (both voluntary and permanently–staffed), are coordinated to avoid conflict, wastage and oversights.

2.4 Ambulance Services in Victoria

Overview of Current Legislation

This section of the report provides a brief overview of the current legislation, including amendments to the Act passed in the Autumn 1998 sittings of Parliament. The amendments will be proclaimed in stages, with full commencement planned for December 1999.

An overview is also provided in relation to other legislation that has important implications for ambulance services in context of the current review.

Ambulance Services Act 1986

Part 1 (sections 1 – 3) of the Act sets out the purposes of the legislation, commencement provisions, and definitions. The purposes are to:

- Restructure the provision of ambulance services and to enable future restructuring.
- Provide for education and training associated with ambulance and related services.
- Make general provision relating to ambulance services.

Part 2 (sections 4 – 8), which provides for the Victorian Ambulance Board, is to be repealed. Provisions relating to the Board do not reflect current practice, and the Board has not operated for many years.

Part 3 (sections 9 – 14) sets out the functions and powers of the Secretary to the Department (referred to in the Act as the Chief General Manager). The 1998 amendments add the provision of education and training for ambulance and related services to the Secretary's functions, consistent with the mainstreaming of ambulance education and training, to Monash University in the first instance. Many of the Part 3 provisions are prescriptive, including those in respect of areas such as policy development, minimum service standards and clinical standards; performance monitoring; industrial relations; funding; and performance reporting and accounting. There are key questions regarding whether a legislative base should be required in relation to many areas, such as current requirements for inspection of facilities of ambulance services, and for appointment by the Secretary of a Director of Ambulance Services.

Part 4 (sections 15 – 22) sets out the objectives and powers of ambulance services; and provides for the operation of committees of management. The objectives of an ambulance service, as set out in section 15, are to:

- Respond rapidly to requests for help in a medical emergency.
- Provide specialised medical skills to maintain life and to reduce injuries in emergency situations and while moving people requiring those skills.
- Provide specialised transport facilities to move people requiring emergency medical treatment.
- Provide services for which specialised medical or transport skills are necessary.
- Foster public education in first aid.

The powers set out in this Part enable an ambulance service to:

- Charge reasonable fees for services rendered.
- Operate or participate in a subscriber scheme.
- Provide services to members of, or contributors to, a health fund under an agreement with a health fund.
- All things that are necessary or convenient to enable the service to achieve its objectives.

Part 4 also contains provisions in relation to the membership, functions, powers, meetings and procedures of committees of management; and the appointment, suspension and dismissal of Chief Executive Officers (referred to in the Act as Regional Superintendents). The 1998 amendments remove prohibition on payment of fees to members of committees of management of ambulance services (although a member of a committee who is also a member of the Legislative Council or of the Legislative Assembly is not entitled to be paid remuneration as a member of the committee).

Part 5 (section 23) provides for the creation, modification and abolition, by the Governor in Council, of ambulance services. An ambulance service is a body corporate having perpetual succession, and is to be governed by a committee of management. Part 5 contains provisions in relation to the transfer of assets, and requirements relating to transfer of ambulance service employees. In addition, specific provisions are set out in relation to the Alexandra and District Ambulance Service.

Part 6 (sections 24 – 32), which provides for the Ambulance Officers Training Centre (AOTC), is to be repealed. The AOTC will be abolished and, as noted above, the provision of education and training for ambulance and related services has been added to the functions of the Secretary. These amendments enable the mainstreaming of education and training of ambulance officers to the education sector. The Department has recently entered arrangements with Monash University for the delivery of ambulance officer education.

Part 7 (sections 33 – 38) contains a number of general provisions, including:

- Acceptance of gifts and bequests by an ambulance service.
- Requirement for the Secretary's approval of capital expenditure in excess of $50,000.
- Appointment of an administrator.
- Making of by–laws.

Part 8 (section 39) makes it an offence under the Act to:

- Use the words 'ambulance' or 'ambulance service', or to use insignia, without the authority of the Secretary.
- Represent that the person is associated with an ambulance service unless such an association exists.
- Impersonate an ambulance officer.

A penalty of 20 penalty units (representing a maximum penalty of $2000 which is able to be imposed) applies in respect of these offences.

Such prohibitions do not apply to use of the words 'ambulance' or 'ambulance service' by the St John Ambulance Association and the St John Ambulance Brigade; or to use of the words 'animal ambulance' by bona fide animal welfare organisations.

Part 9 (section 40) sets out powers of the Governor in Council to make regulations, including prescription of the qualifications of ambulance officers, insignia, uniforms, title and emblem of the Ambulance Service Victoria, and control districts. It should be noted that while these powers are contained in the Act, to date no such regulations have been made.

Part 10 (sections 41 – 47) contains various transitional provisions, and powers of ambulance services in relation to investments and to the borrowing of money.

Provisions identified in the brief for specific consideration in the NCP review are:

- Powers of the Secretary to direct ambulance services (section10).
- Powers of the Secretary to grant subsidies and to impose conditions (section12).
- Powers of the Governor in Council to create, modify and abolish ambulance services (section 23).
- Requirement to obtain the Secretary's approval for capital expenditure in excess of $50,000 (section 34).
- Powers of committees of management to make and amend by–laws (section 36).
- Prohibition on use of the words 'ambulance' or 'ambulance service', or of insignia (section 39).
- Powers of the Governor in Council to make regulations prescribing qualifications, insignia, uniforms etc (section 40).

Other Relevant Legislation

Financial Management Act 1994. As a government business, financial management of an ambulance service must be conducted within the requirements of the 1994 legislation. The purposes of this legislation are to:

- Improve financial administration of the public sector.
- Make better provision for the accountability of the public sector.
- Provide for annual reporting to the Parliament by departments and public sector bodies.

The ***Emergency Services Superannuation Act 1986*** establishes an Emergency Services Superannuation Board and Scheme to provide superannuation benefits for persons employed in the emergency services. The Act entitles a range of people employed by emergency services to choose to contribute to the Scheme, including a person who is employed by an ambulance service or by the AOTC.

The ***Emergency Management Act 1986*** provides for the organisation of emergency management in Victoria, including preparation and review of the state emergency response plan referred to in the legislation as DISPLAN. Together with other emergency services, municipal councils and a range of other government and non–government agencies, ambulance services play an integral role in emergency response in Victoria.

The ***Road Safety Act 1986*** and ***Road Safety (Traffic) Regulations 1988*** contain a number of provisions relevant to ambulance services. The Road Safety Act makes provision for standards of registration of vehicles, including conditional registration allowing the fitting of lights and sirens in emergency vehicles.

The Road Safety (Traffic) Regulations define ambulance to include:

- A vehicle operated by or on behalf of Ambulance Service — Victoria.
- A vehicle operated by or on behalf of an ambulance service of another State, Territory or the Commonwealth.
- A vehicle operated as an ambulance by the Australian Defence Force.

An emergency vehicle includes an ambulance conveying sick or injured persons to a place of medical treatment; or conveying emergency supplies, equipment or personnel to a site where those supplies, equipment or personnel are or may be urgently required for the treatment of sick or injured persons. Emergency vehicles are exempted from a range of general provisions of the regulations, such as stopping at traffic control signals, and driving or overtaking on the usual side of the road.

The ***Drugs, Poisons and Controlled Substances Act 1981*** and ***Drugs, Poisons and Controlled Substances Regulations 1995*** provide for the issue of licences, permits and warrants to persons to possess and administer various drugs and poisons listed in Schedules to the Regulations. Permits for ambulance services to purchase drugs for use require demonstrated accountability through the service, including adherence to clinical standards protocols. The effect of these provisions is to limit the issue of permits to services operated by or on behalf of Ambulance Service — Victoria.

Other legislation that contains provisions of relevance to the provision of ambulance services includes:

- *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*
- *Health Act 1958*
- *Medical Practice Act 1994*
- *Medical Treatment Act 1988*
- *Mental Health Act 1986*
- *Metropolitan Fire Brigades Act 1958*
- *Nurses Act 1993*
- *Occupational Health and Safety Act 1985*

Structure and Role of Ambulance Services in Victoria

As discussed above, ambulance services in Victoria are currently provided by the Metropolitan Ambulance Service (MAS), Rural Ambulance Victoria (RAV), comprising the five former major rural ambulance services (North Eastern, North Western, Western, South Eastern and South Western), and the Alexandra and District Ambulance Service. The latter service is operated largely on a voluntary basis with minimal government funding. Each service is responsible for delivery of ambulance services in distinct geographic areas of the State. MAS covers the Melbourne metropolitan area and Mornington Peninsula, and is also responsible for the provision of air ambulance services throughout the State. Ambulance services are an integral part of the health system. The timeliness and quality of emergency medical transport and associated pre–hospital care can save lives, reduce the impact of medical emergencies on patients and lower overall treatment costs.

Historically, ambulance services were operated as charitable organisations. Over time, however, with rising costs from changes in medical technology and with rising community expectations, the ambulance services have become increasingly reliant on government for funding, especially in the broader context of a universal public health system and medical insurance arrangements. The ambulance services of today are statutory corporations answerable to government.

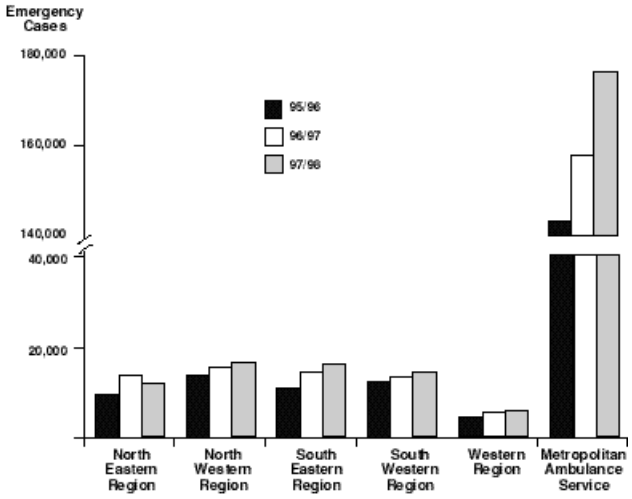
The principal components of an ambulance service are as follows:

- *Call taking and dispatch* — a communications and scheduling function is vital in ensuring rapid and effective response and relies on computer and communications technology, skilled staff and appropriate protocols.
- *Emergency medical transport* — rapid response by specially equipped ambulances and trained officers to time–sensitive medical emergencies and subsequent transport of patients to hospital. Includes emergency response (code 1) where lights and sirens are required and urgent response (code 2) for urgent cases that do not require lights and sirens.
- *Pre–hospital care*— early and effective medical intervention by ambulance officers at the scene or en route to the hospital is often critical in both saving lives and in reducing the impact on the patient and cost of further treatment in the medical system. Ambulance services sometimes provide other clinical services to the community, especially in rural areas.
- *Non–emergency medical transport* — (code 3) inter–hospital transfers and stretcher and clinic car transport of medical cases that are less time–sensitive.
- *Major incident/disaster preparedness* — in concert with other emergency service organisations and agencies.

Important support activities include communications, fleet management, and the normal corporate services functions as well as membership services for subscribers.

The number of emergency and non–emergency cases attended by ambulance services in rural and metropolitan Victoria is shown in Figures 2.1 and 2.2.

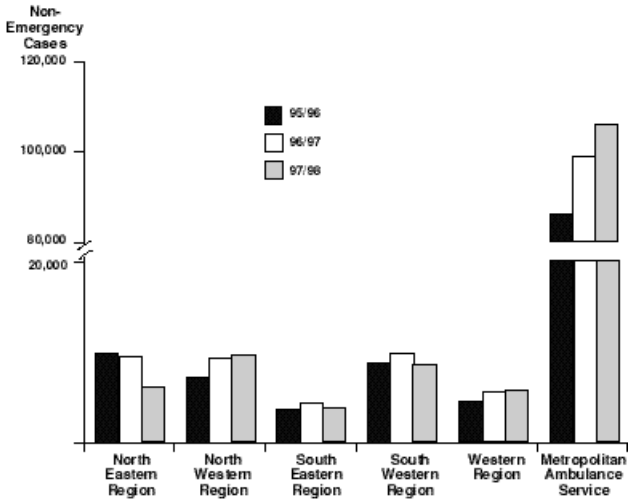
Figure 2.1 Number of Emergency Cases in Rural and Metropolitan Victoria



Note: Data quality for 95/96 is affected by an industrial dispute between 15 September and 14 December 1995

Source: Ambulance Service annual reports; figures for rural services are recorded in Health Services Agreements.

Figure 2.2 Number of Non–emergency Cases in Rural and Metropolitan Victoria



Note: Data quality for 95/96 is affected by an industrial dispute between 15 September and 14 December 1995

Source: Ambulance Service annual reports; figures for rural services are recorded in Health Services Agreements.

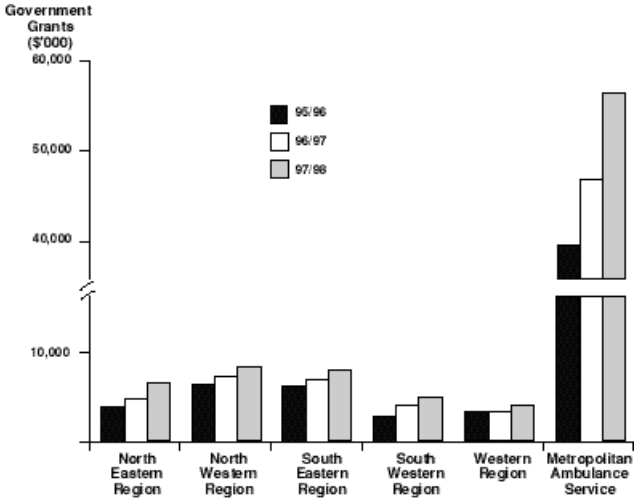
Funding of Ambulance Services

Sources of funding are:

- *Membership subscription scheme*, which covers subscriber patients for the full cost of emergency ambulance services; and also non–emergency services, with the authorisation of a doctor. The scheme provides Australia wide 'coverage'. Although still a profitable segment for most ambulance services, there has been a steady downward trend in membership numbers over recent years. Subscriptions to MAS, for example, declined by approximately 10 per cent between July 1994 and December 1997, although this decline might at least be arrested with the Government's adoption of a full cost recovery pricing scheme applicable to non subscribers. Subscriptions are not set on an actuarial basis, and provide significant net revenue to ambulance services.
- *Patient transport fees*, which represent revenue collected for emergency and non–emergency transport provided to patients who are not members of the subscription scheme, and are not covered by the Community Services Obligation (CSO), under which ambulance services provide free services, primarily to Healthcare card holders. Department of Veteran Affairs (DVA), the Workcover Authority, the Transport Accident Commission (TAC), public hospitals and major sporting bodies such as the VRC and the AFL are major purchasers of patient transport services. The fees may be paid by patients or, in the case of inter–hospital transfers, by hospitals. Until recently, the ability of the ambulance services to recover the full cost of service provision has been limited. The MAS pricing structure, for example, allowed for approximately 47 per cent of the total cost of emergency transport. However, as noted above, MAS has recently been given approval to implement a pricing policy that allows it to invoice its emergency transport (for 'paying' patients) on a full cost recovery basis.
- *Government grants.* Ambulance services are expensive, and a problem arises in relation to the ability of low–income households to pay for the service. The Government has responded by requiring that these services be

provided free to pensioners and Healthcare card holders. To help fund this, the Government has historically used a 'deficit funding' model, which means that its grants to ambulances services have been designed to bridge the gap between their expenditure and revenues. Furthermore, DHS has indicated its intention to shift to an output based budget. The Government's contribution to the funding of ambulance services in Victoria is illustrated in Figure 2.3.

Figure 2.3 Government Funding of Ambulance Services in Victoria 1995/6 to 1998/9



Note: Data does not include indirect contributions by the Department of Human Services.

Source: Ambulance service annual reports.

An overview of the basic parameters governing the provision of ambulance services in Victoria is provided in Table 2.1, which distinguishes between the metropolitan and rural ambulance services, and between emergency and non–emergency responses.

Table 2.1 Overview of Ambulance Services in Victoria

	METROPOLITAN		RURAL	
	Emergency	**Non-emergency**	**Emergency**	**Non-emergency**
Regulation	DHS – regulated market. MAS is the sole provider. Strong powers to direct, provide grants and set conditions. Occupational restrictions. Administration of drugs. Use of term 'ambulance'. VicRoads – sirens, lights, etc. MAS – internal service delivery, QA and clinical standards.	DHS – contestable market, 2-tiered system. MAS (and sub-contractors) internal service delivery, QA and clinical standards. Others – no external standards or regulatory framework for private sector firms. Report of a ministerial review of non-emergency transport recently released.	DHS – regulated market. One party is licensed for each geographic area. Strong powers to direct, provide grants and set conditions. Occupational restrictions. Administration of drugs. Use of 'ambulance'. VicRoads – sirens, lights, etc. Rural Ambulance Services – internal standards. The 5 major rural ambulance services have recently been amalgamated.	DHS – contestable market. Rural Ambulance Services - internal standards. Others – no external standards or regulatory framework for private sector firms. The 5 major rural ambulance services have recently been amalgamated. Report of a ministerial review of non-emergency transport recently released.
Purchaser	DHS – defines service standards and sets certain prices and subscription rates. DHS – CSO requirement for pensioners and Healthcare card holders. DVA purchases services on behalf of non health care card holder veterans TAC and Workcover cover motor vehicle and workplace related accidents Hospitals – for interhospital transfers Other patients – pay fees (or the gap) and can subscribe (full cover) or insure (part cover).	DHS – defines service standards and sets certain prices and subscription rates. Hospitals – competitive tenders for contracts for interhospital transfers, etc. DHS – CSO requirement for pensioners and Healthcare card holders. DVA purchases services on behalf of non health care card holder veterans TAC and Workcover cover motor vehicle and workplace related accidents Other patients – pay fees and can subscribe (full cover, if authorised by a doctor).	DHS – defines service standards and sets certain prices and subscription rates. DHS – CSO requirement for pensioners and Healthcare card holders. DVA purchases services on behalf of non health care card holder veterans TAC and Workcover cover motor vehicle and workplace related accidents Hospitals – for interhospital transfers Other patients – pay fees (or the gap) and can subscribe (full cover) or insure (part cover).	DHS – defines service standards and sets certain prices and subscription rates. Hospitals – competitive tenders for contracts for interhospital transfers, etc. DHS – CSO requirement for pensioners and Healthcare card holders. DVA purchases services on behalf of non health care card holder veterans TAC and Workcover cover motor vehicle and workplace related accidents Other patients – pay fees and can subscribe (full cover, if authorised by a doctor).
Provider	MAS – 62 emergency response locations, 116 emergency response vehicles. Coordinates statewide air ambulance services. MFB – pilot first responder program in a number of eastern and south eastern suburbs.	MAS – provide stretcher (outsourced) and ambulatory services (in-house, 19 staff). Issues include competitive neutrality and access to CSO funding. Competitors – not for profit bodies, private medical transport providers.	Rural Ambulance Victoria – 114 ambulance stations in total. 5 separate communications centres. Major users of air ambulance services. Alexandra and District Ambulance Service – largely volunteer, minimal government funding (3 stations).	Rural Ambulance Victoria – generally uses emergency response vehicles and officers for non-emergency response given significant spare capacity. Alexandra and District Ambulance Service Competitors – not for profit bodies, private medical transport providers.

2.5 Interstate and International Models

International Comparisons

There is a multitude of models for the provision, funding and organisation of emergency health services around the world. Typically, in western countries, governments assume the role of funder and provider of emergency services, although there are also cases of private provision of services under contract or franchise. Emergency services are not always provided by dedicated ambulance services – providers range from fire departments to civil defence agencies. Most countries make a distinction between emergency and non–emergency cases, and there is a growing realisation that this has implications for the most appropriate type of service and staff qualifications required.

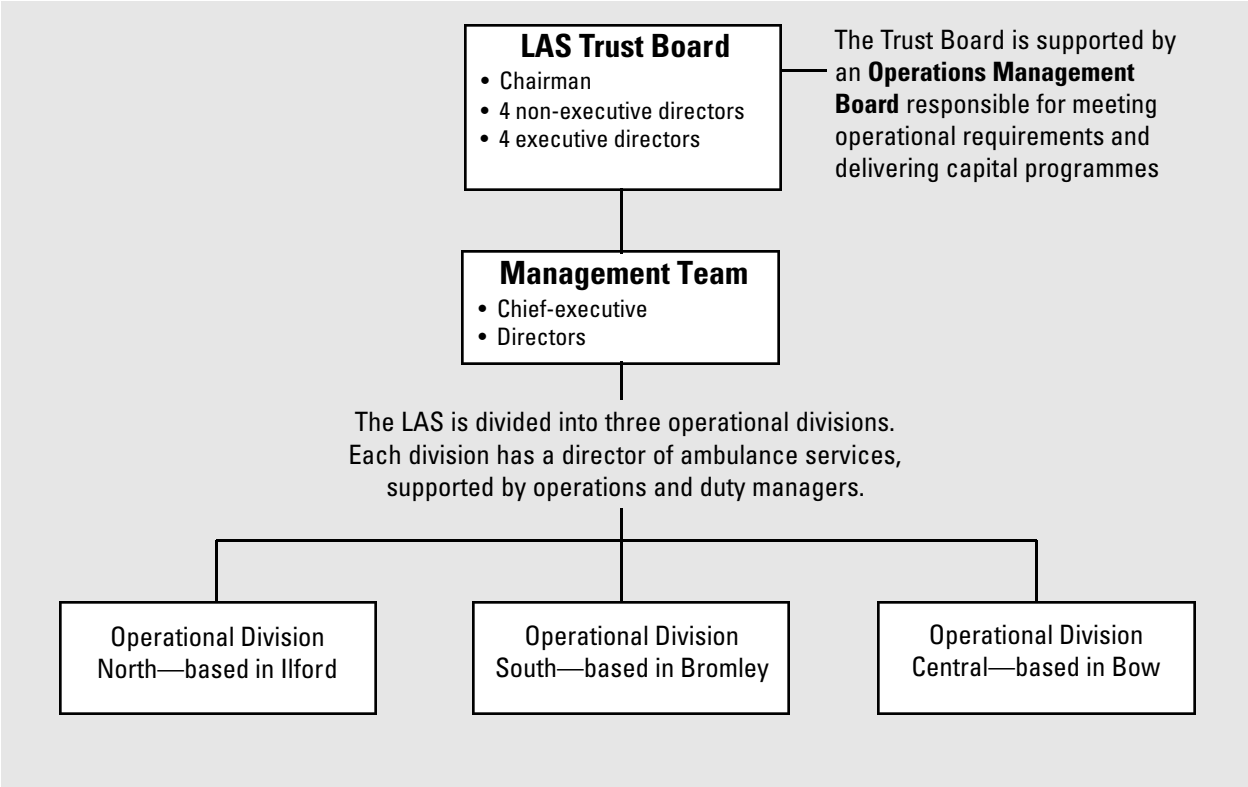
United Kingdom

In the United Kingdom, emergency health services are overseen nationally by the National Health Service (NHS) which sets national standards and monitors performance. An NHS medical advisory committee sets medical and clinical standards and practices. The NHS is the primary funder of ambulance services, which are purchased by Area Health Authorities (AHAs) from NHS Ambulance Service Trusts.

The 35 NHS Ambulance Service Trusts are the main providers of ambulance services in Britain. They have managerial independence from the NHS, with varying geographic areas of responsibility. Some trusts cover very large areas or populations, for example, one service caters for the whole of Scotland, and the London Ambulance Service caters for the whole of London. There has been recent discussion of amalgamating some of the smaller trusts, as has already occurred with the Hereford and Worcestershire, and Bedfordshire and Hertfordshire services.

Each Ambulance Trust has a Board of up to ten people, made up of four or five non–executive directors drawn from outside the organisation, and four or five executive officers. The Chairman is drawn from the non–executive directors. For example, the organisation structure of the London Ambulance Service is provided in Figure 2.4.

Figure 2.4 Structural Organisation of the London Ambulance Service



A review of ambulance services conducted several years ago by the NHS recommended splitting cases into *emergency, urgent* and *patient transport* categories (see Box 2.1 for definitions). Purchaser–provider models were introduced that were suitable to the requirements of each type of case.

Emergency and Urgent

Ambulance services in the categories of emergency and urgent are, in each geographic area, provided exclusively by ambulance services operated by the NHS Trusts, under contract with the NHS Area Health Authorities. Contracts are periodically renegotiated and include performance requirements, such as response times, set by the AHA. Contracts require emergency and urgent cases be attended by a two person crew made up of an ambulance technician and paramedic.

Patient Transport

Patient transport services are not purchased by the Area Health Authorities, but by the agencies in direct need of the service, for example, hospitals and GP fundsholders. These services are fully contestable and have to date been contracted to both non–ambulance services as well as ambulance services run by the NHS Trusts.

Box 2.1 Ambulance Cases in the United Kingdom

Emergency

Emergency cases are defined as requests for transport generally made by a 999 call (the emergency number in the UK) and generally include heart attack, sudden illness, accident, some maternity admissions and other immediately life threatening calls. (There were 2.6 million emergency journeys reported in 1996/97 in the UK.)

Urgent

Urgent cases are defined as requests for transport not requiring immediate attendance but with a definite time limit, such as hospital admissions (1.1 million).

Patient Transport

Patient transport services are deployed in all other cases of request for transport that are not urgently required (14.8 million).

Training

Until recently, most training was conducted by in–house training departments. Now, there are several external providers of training services, including universities offering courses up to degree level. The NHS sets national training and competency standards.

United States

In the United States, the provision and funding of emergency health services is entirely coordinated at the local urban or rural level. Several organisations do provide policy advice at a national level, although none of their recommendations are binding. The National Highway Safety and Traffic Authority within the Department of Transport operates more as a facilitator than standard setter, for example by providing products and services such as an outcome measures database and quality programs. Clinical policy and qualification standards are set by the National Association of Emergency Medical Services Physicians and the American College of Emergency Physicians. The American Ambulance Standards Association has recommended an eight minute response time standard.

Most States impose some regulatory control by an Emergency Services Act, which usually requires all providers to have a medical director who is responsible for the quality of the treatment provided by their ambulance service.

Across the US, there is a wide range of models for the provision of emergency services, which by and large, are financed by local government taxes. Local government either acts as the service provider itself or contracts services via a tendering process. In the US, as in the UK, there is a distinction between emergency and non–emergency patient transport services, the latter being almost entirely open to market forces. Typically, the standard of services and response times is very good in large urban areas due to the concentration of population and services, whereas response times in urban fringe and rural areas, where services are not as well coordinated, are not as consistent.

Several models of service provision of emergency services across the US are described below:

- *Public Utility Model* — This model operates where emergency services are publicly funded and contracted out by local government (typically either taken up by private ambulance services or fire departments). Contracts specify performance standards (eg, Richmond, VA). This model has increased in prominence throughout the US in recent years.
- *Fire Department Model* — The fire department provides the emergency services on behalf of the local government (eg, Los Angeles County). The original impetus for this arrangement was the need for fire departments to generate income in the face of budget cuts and a need to utilise fire officers in their downtime. Under this model, a first response is provided by a fire truck (or ambulance) with a second vehicle providing more qualified follow–up. Non–emergency transport is usually provided by private ambulance (eg, Shepherd Ambulance).
- *Police Department Model* — This is similar to the Fire Department Model, with the police department providing emergency services on behalf of the local government (eg, New Orleans).
- *Emergency Services Model* — Emergency services are provided by any of the police, fire and ambulance services (eg, Pittsburgh). Non–emergency services are provided by a private ambulance service.
- *Private Sector Model* — In some areas, privately operated and owned ambulance services are funded by cost recovery and member subscriptions. For example, in Louisiana, Acadia Ambulance Service provides a ground and air emergency response service to Louisiana residents and engages in other business such as contract emergency services to the offshore industry. Acadia provides around 51 per cent of Louisiana's ambulance services.
- *Volunteer Model* — There are several examples of volunteers running emergency services in rural areas that are not serviced to the same degree as the larger cities (eg Arcadia Ambulance Service, Wisconsin).
- *Retrieval Model* — An emerging model of emergency service is for privately funded vehicles and helicopters to respond to emergency cases on behalf of large hospitals. The rationale for the large expense is that the hospitals can expect to obtain any consequential business from the service. This is a purely private service.
- *Health Maintenance Organisation (HMO) Model* — This is a managed care model whereby the provision of emergency services is coordinated by a patient's insurer. The insurer, the first point of contact in an emergency situation, organises for the provision of emergency services by a contracted provider. This is also very much a growing service in the US.

Training

There are two main categories of trained service providers in the US: a 'basic' and a 'paramedic' qualification. Training in the US is either provided in–house (eg, Seattle) or by some other public and privately provided training courses. Some universities run two to four year degree courses in paramedics, usually as part of a wider degree in humanities. However, the portability of qualifications is restricted due to the absence of national training standards.

Canada

Canadian emergency health services differ by province and follow models that are a mix of the Australian and US models. There is little national coordination and no national competency standards in Canada.

In British Columbia, services are very similar to the Victorian model, whereby the State Health Department runs the state wide British Columbia Ambulance Service, with state wide policy and qualification standards. In other provinces, services are more fragmented and often provided at a local level.

Ontario

Ontario provides an example of a province in which the organisation of ambulance services is under going fundamental change. As part of a wider initiative to realign funding and service responsibilities between the provincial and local governments, recent change to the legislative framework is transferring responsibility for the funding and delivery of ambulance services from the province to municipalities. Ownership and operational responsibility, as well as future

replacement costs, for existing ambulances and equipment will be transferred progressively as municipalities assume full responsibility. While the Ministry of Health at provincial level will continue to set standards for the type and level of services to be delivered, the municipalities will be responsible for determining the best way to meet those standards.

Municipalities will have to decide which model of service delivery to adopt — ie, whether to become the direct provider of ambulance services, to conduct a tender for the highest quality service, or continue with the existing service. The municipal governments will be responsible for funding all costs of ambulance services. However, co–payment fees (presently $45 per patient per journey) will continue to be set by the Ministry of Health. The Ministry will retain the ambulance dispatch function, and will assign the closest available ambulance vehicle irrespective of municipal boundaries. Where this involves ambulance services crossing municipal borders, municipalities are expected to formulate cost sharing arrangements.

Strategic planning, service system management and service delivery responsibilities in the Ontario model are set out in Table 2.2.

New Zealand

There are presently fifteen ambulance services operating in six regions of the country — three are hospital services, six are provided by St John Ambulance, five are private providers, and there is one charitable trust called the Wellington Free Ambulance. There do not appear to be any barriers that would prohibit the establishment of any prospective ambulance services.

There is some degree of national coordination of ambulance services through the operation of The New Zealand Ambulance Board based in Wellington. The six regions are members of the Board. The Board has not had a very prominent role to date. There are plans to restructure the Board in an effort to strengthen its coordination function.

An anticipated result of the restructure will be more stringent requirements for ambulance services in New Zealand to meet criteria with respect to vehicle, training, response times, and clinical standards (which are presently overseen by the Ambulance Services Medical Committee). There will be three separate bodies created: an Ambulance Education Council to oversee industry training; an Ambulance Accreditation Authority

Table 2.2 Ontarian Provincial and Municipal Government Roles and Responsibilities: Land Ambulance

The Province	Municipalities
– Integrates land ambulance service with all other health care initiatives eg, rural health and hospital restructuring – Legislates, sets standards, establishes guidelines, protocols and best practices	– Plan for funding and service delivery – Review contracts – Consult with neighbouring municipalities
– Ensures the provision of land ambulance services within the provincial emergency health services system – Licensing of services and staff	– Develop methods for cost sharing – Consult with province
	– Full responsibility and accountability for funding and delivery – Ensure essential linkages with clients, customers and service providers – Public and client education

Source:Who Does What: Toward Implementation, Province of Ontario, Canada, 1998.
See www.mmah.gov.on.ca:80/business/wdw/sectioni–e.html

will be a self–regulating licensing body; and a third body that will deal specifically with 'industry advocacy'.

Competition policy in New Zealand is enforced and monitored by the New Zealand Commerce Commission. In 1999, the Commerce Commission will specifically investigate health, in particular the Accident Compensation Commission (ACC), which is a major contractor of ambulance services. There will be particular attention focussed on tenders, and from July 1999 some previously government controlled ACC insurance will be opened up to private enterprise.

Interstate Comparisons

Ambulance services in Australia tend to be supplied by either State government bodies or other providers under contract, such as St John Ambulance. Recent changes in a number of States and Territories are resulting in changes that are placing a greater emphasis on making ambulance services potentially more contestable, usually by giving the relevant Minister the authority to choose the most appropriate provider. Table 2.3 provides a summary of the legislative basis of ambulance services in States and Territories of Australia. It should be noted that Table 2.3 deals with 'core' ambulance services legislation and does not address other related legislation, such as regulation of lights and sirens under road safety traffic provisions.

Table 2.3 Ambulance Services – Legislative Base

State or Territory	Current Legislation	Key Ambulance Service Features	Recent Changes/Proposals	NCP
ACT	Ambulance Service Levy Act 1990 is to be superceded by Emergency Management Bill 1998 (Draft Bill tabled in ACT Assembly Dec 98, expected to be referred to Committee)	Direct government service	Emergency Management Bill 1998 provides broad framework for emergency services – includes specific provisions for Ambulance Service & SES at this stage, Fire and Bushfire to be dealt with later. Under draft legislation, the Minister will have authority to approve an application to provide Ambulance Services, subject to criteria, standards and restrictions.	New legislation deemed not to contain restrictions.
NSW	Ambulance Services Act 1990	Ambulance Service (AS) is a statutory corporation; however, the Health Administration Corporation determines conditions of employment of staff, conducts Enterprise Bargaining.		No NCP review planned
NT	Nil	AS an incorporated association, operates under contract to NT Government.		No legislation to review.
QLD	Ambulance services Act 1991	AS is a statutory authority acting as a division of a Govt department.	Nov 98 amendments provided for abolition of Ambulance Board, and for Director–General of Emergency Services to become Chief Exec of AS.	NCP review to be conducted as part of current review of funding
SA	Ambulance Services Act 1992 (to be amended)	AS provided by SA Ambulance Service, which is a joint venture between St. John Ambulance Australia and the Government of SA.	Amendment Bill provides for withdrawal of St John Ambulance. Under draft legislation, the Minister may grant a licence to a suitable person subject to conditions, etc.Transfer of assets has been dealt with separately under St John (Discharge of Trusts) Act 1997.	No NCP review planned
TAS	Ambulance Services Act 1982	AS is direct Government service. 1 private operator (2 vehicles) has entered non–emergency market.	Amended 98 (Director of Ambulance Services may approve licence to operate an AS)	No NCP review planned
VIC	Ambulance Services Act 1986	AS has GBE status	– Amended Autumn 98 (mainstream Ambulance Officer training, remuneration of committee members) – Proposed amendment Autumn 99 (transfer of assets/bequests) – Full scale review, proposed amendments Autumn 2000	NCP Review to be completed by March 99
WA	Nil	AS provided by St John – services tendered as a block on state–wide basis (except inter–hospital transfer)		No legislation to review

3. KEY CONCEPTS

Key Points

- The justification for government intervention in markets is based around the idea of **market failure**. Intervention can take various forms including **regulation** and **public provision**. The cost of government intervention itself also needs to be considered such as the problems associated with public provision.
- Alternative **purchaser-provider** models are available that separate the regulator, purchaser and provider roles of government. Where the provider role is contestable, it should be provided by the most efficient provider. Competitive neutrality is an integral issue for purchaser-provider models.
- Purchaser-provider models focus on the output and outcomes for the community, rather than the traditional focus of government bureaucracies on inputs (such as budget and staff numbers) and processes (such as legal, regulatory and administrative processes).
- A host of other factors need to be considered when implementing government reform. These include timing of program implementation, introducing standards for measuring and assessing performance, measuring quality of output, ensuring that funding is directly linked to performance, and installing an equitable user charges structure.

3.1 Competition, Market Failures and Regulation

Competition generally provides a mechanism for the efficient allocation of resources by ensuring that economic rents can only be gained by firms that provide value to consumers through increased efficiency and innovation. In order for a market to be competitive, there must be free entry and the market participants must behave as rivals.

However, due to reasons of market failure (as outlined in Section 2.2), governments interfere in the mechanism of the free market to ensure the provision of a host of goods and services deemed beneficial to all members of society. Government intervention is in either of two forms. Governments can directly *provide* goods and services, or governments can regulate the provision of goods and services by private providers. For instance, regulation may be in the way of price setting, setting minimum standards of quality, and licensing.

In more recent times, there has been an acknowledgment that regulatory intervention may introduce new problems. Breyer identified the major types of market failure and the appropriate types of regulatory response, and warned that 'imperfect' markets do not automatically require government regulation, as regulation can often result in a less desirable outcome than the original 'imperfect' market. For example, in the case of public provision (the form of intervention that tends to be adopted in the case of ambulance services), there may be a number of reasons why public sector involvement may be considered less desirable than provision by the private sector. This issue is addressed in the following section.

3.2 Public Provision

Historically, in many cases, the Government may have been the only player in a position to provide particular goods and services. However, as markets have developed and industries have matured, this is no longer necessarily true. As a result, governments are increasingly looking to benchmark government service providers, and to test the ability of the private sector to undertake services.

When the private sector is able to supply an equivalent service, there are good reasons in many cases for the government not to provide the service itself. There are generally accepted problems associated with government bodies

undertaking business activities, relating to:

- Clarity of objectives.
- Political interference.
- Managerial autonomy.
- Public sector employment constraints.
- Access to capital.

Significant evidence has emerged in recent decades questioning the performance of public business enterprises relative to private business enterprises (see Box 3.1). One possible solution to the problems of government ownership is corporatisation, where a business is given a business–like structure and placed at arm's length from government. This can reduce, but generally does not eliminate, the problems listed above. For a business to be worth corporatising, it has to be commercially viable and of sufficient scale to justify the significant overheads involved. Corporatisation has sometimes been a precursor to privatisation.

'Ring-Fenced' Business Units

An alternative to corporatisation is an internal 'ring–fenced' business unit, which can provide an intermediate level of cost, price and performance transparency and an intermediate level of managerial autonomy. This option is more attractive for smaller scale businesses that have strong synergies with regulatory or policy roles. A business unit can also serve as a good intermediate step to test out the viability of businesses prior to potential corporatisation.

Box 3.1: Relationship between Performance and Ownership

In the 1960s and 1970s, there was a major world-wide expansion in public ownership of enterprises, followed by a period of generally disappointing performances. Since this time, there has been a sea change in the attitude of governments, with many thousands of Government Business Enterprises (GBEs) being privatised, most of them since 1990. This provides a wealth of experience for analysis.

Early studies concluded that there is no compelling evidence that ownership influenced efficiency, but rather it was competition and regulation that were more important in determining economic performance.[6]

In 1994, the World Bank published an analysis of privatisation experience from four countries and concluded that, while there are examples of well-run, profitable, efficient GBEs, these tend to be exceptions, and that on average GBEs function poorly and impede private sector development. The World Bank estimated that privatisation produces benefits of efficiency and innovation, if implemented correctly.

Markets and public ownership were found to be linked in ways that can reduce competition, even without a significant market failure:

- The budgetary impact of GBEs often gives governments incentives to protect GBEs from competition.
- Burdens imposed on GBEs by governments can intensify the sense of obligation to protect them from competition.

These burdens often included maintaining employment, regional development, provision of jobs and power to certain groups, or rent-seeking. The paradox is that public ownership is often created in order to correct or reduce market failures but it can sometimes perpetuate or aggravate them if uncompetitive monopoly behaviour cannot be effectively addressed.

Gains in economic performance were also projected by the World Bank even where market structures did not change. Private owners were able to overcome investment constraints imposed by government, and to operate the companies more efficiently. Privatisation can greatly simplify the principal-agent problem, with the move from multiple stakeholders and disparate objectives under public ownership to a single owner with one overriding profit objective creating the potential for efficiency gains.

The key lessons from this experience with direct relevance to ambulance services are that:

- Privatisation of GBEs is most successful where it is used to increase competition and reduce monopolistic behaviour, and it is important that any restructuring occurs prior to privatisation.
- Privatising GBEs that produce tradeable goods is easier as regulation is not required, while privatisation of monopolies requires and a well developed and effective regulatory capacity.

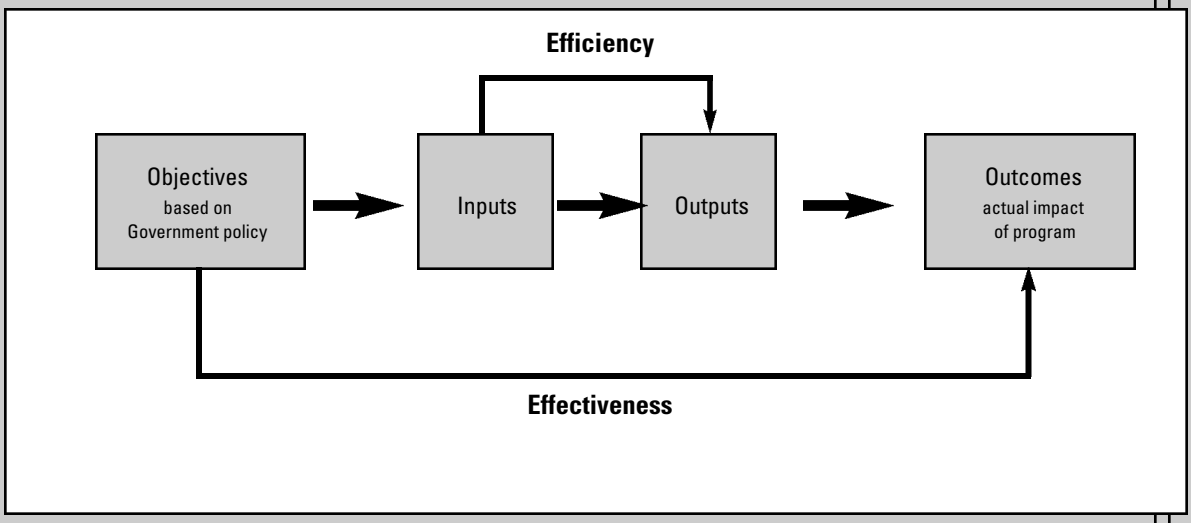
6 Vickers, J and G. Yarrow, *Privatisation: an Economic Analysis*, Cambridge Mass., MIT Press; and Hemming, R. and A. Mansoor, *Privatisation and Public Enterprises*, International Monetary Fund Occasional Paper 56, Washington D.C., 1988.

Box 3.2: The Efficiency and Effectiveness of Government Programs

Figure 3.1 provides a simple representation of the processes and relationships by which a government program works, from the development of government policy to the delivery of services and their impact upon the community.

In the initial stage, the development of policy, the program objectives are defined and the desired outputs and outcomes of the program are specified. The next stage, the delivery of services, is represented by the transformation of inputs (dollars, labour, technology) into outputs (the actual services provided). The outcomes of a program are its effects (both intended and unintended) on the clients of the program and the community as a whole. For example, the total number of teaching hours is one output of the Victorian vocational education and training (VET) system, whereas outcomes for students of the VET system might include higher future earnings or an improved ability to find a job.

Figure 3.1 Government Programs – Processes and Relationships



Source: Commonwealth Department of Finance

A key objective of the public sector reforms is to improve the performance of government service delivery programs, particularly in terms of efficiency and effectiveness. As shown in Figure 3.1, **efficiency** is concerned with the relationship between an organisation or program's inputs and its outputs. A program is operating efficiently if it is minimising the amount of inputs it requires to produce a given quantity of outputs (or, alternatively, if it maximises its outputs for a given amount of program inputs). Effectiveness refers to the extent to which actual program outcomes reflect desired program outcomes. That is, effectiveness measures the extent to which program objectives are being achieved.

3.3 Government Service Delivery

Objectives, Inputs, Outputs and Outcomes

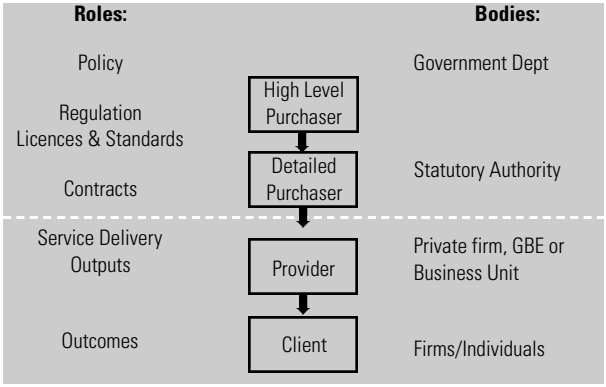
Traditionally, the first step in the strategy of the government to restructure the delivery of core government services has been to place a greater focus on desired policy outcomes rather than processes and inputs. In administering government programs and providing services, government bureaucracies have traditionally focussed on inputs (such as budget and staff numbers) and processes (such as legal, regulatory and administrative processes). This has often been to the detriment of a focus on the original objectives of the program or service: the output and the outcomes for the community (see Box 3.2). This is partly a function of the increased accountability expected of the public sector, but it is also a result of the frequent lack of responsiveness of bureaucratic institutions to community needs.

In the private sector, a business in a competitive market that loses sight of customer satisfaction goes out of business. Government agencies have generally been immune to this threat. One of the aims of government is to implement reforms that enhance responsiveness to community needs.

The Purchaser-Provider Model

Under the *purchaser–provider model*, there is a clear separation between the government as *purchaser* of the services and the agency that is the *provider* of the services. The relationship is defined in a *service agreement*. Many different kinds of purchaser-provider models exist. Figure 3.2 illustrates a generic model.

Figure 3.2 A Generic Purchaser-Provider Model



The purchaser–provider model provides potential advantages in terms of:

- Strengthening *accountability* — by making previously implicit, and possibly vague relationships explicit, and basing payment on what is to be delivered.
- Minimising *conflicts of interest*.
- Facilitating *contestability* — the separation of the purchaser and provider roles also opens up scope for competition in the provision of services.
- Increasing *managerial autonomy* — by allowing managers to find the best solutions.
- Enhancing *client focus*.

A purchaser–provider arrangement provides a basis for government services to be provided by the agency that can do so most efficiently, while meeting or exceeding the quality required. It may be that this is a private sector agency. Alternatively, it is quite possible that a corporatised government agency, with previous experience of service delivery, may be the most efficient operator.

3.4 Competitive Neutrality

A purchaser–provider arrangement should ensure that government services are provided by the agency that can do so most efficiently. It may be that this is a private sector agency. Alternatively, it is quite possible that a government agency, with previous experience of service delivery, may be the most efficient operator. In order to determine which agency is the most efficient, it is essential that each contender is operating under the same ground rules. This is known as competitive neutrality. As Table 3.1 demonstrates, government owned business activities can experience both competitive advantages and disadvantages in competition with private businesses.

Table 3.1 Some Potential Competitive Advantages and Disadvantages Affecting Public Sector Departments and Agencies

Potential Advantages	Potential Disadvantages
Exemptions from Commonwealth, State and local taxes	Difficulty in accessing taxation benefits of depreciation, investment allowances and other deductions (eg. through the transfer of taxation losses)
No requirement to return a profit	Public sector employment terms and conditions and higher public sector superannuation contributions
Tied clientele and the opportunity to cross–subsidise commercial operations from monopoly markets	Lower degree of managerial autonomy, for example due to the requirement to comply with Ministerial directives
Immunity from bankruptcy and the threat of takeover	Greater accountability costs given the public sector's reporting and regulatory requirements
Exemptions from various Commonwealth and State legislation	Lack of flexibility in reducing or restructuring corporate overheads
Access to various corporate overheads free of charge (or at reduced rates)	Constitutional or legal constraints
Cash flow advantages through budget arrangements which give agencies access to funds at the start of the financial year	Lack of direct access to capital markets
Cheaper capital financing	
Preferential input to tender specifications	

Source: Industry Commission (1996), *Competitive Tendering and Contracting by Public Sector Agencies* Report No. 48, AGPS, Canberra, p. 294.

Under competitive neutrality, government providers need to compete on the same basis as privately–owned providers and so pricing should correctly identify all attributable costs, direct and indirect, to ensure accountability and transparency of business operations. Measures for ensuring competitive neutrality include the imposition of:

- *Taxation neutrality*, which requires payment of all relevant Commonwealth and State taxes, or imposition of a *Tax Equivalent Regime* (TERs);
- *Debt neutrality*, including charges to account for implicit or explicit government guarantees on commercial or public loans;
- Rate of return requirements to achieve a *commercial rate of return* (RoR) on assets; and
- *Regulatory neutrality*, including, wherever possible, compliance with all relevant Commonwealth and State laws or regulations.

These issues are recognised in the Victorian Government's competitive neutrality policy.

Approaches to Costing

As Table 3.2 shows, different costing methods have the potential to produce very different outcomes because of the different elements that are included in a cost calculation.

Using the Fully Distributed Cost (FDC) approach, direct costs are allocated to the product, while indirect and joint costs are averaged across all products. The cost base will therefore include a proportion of the capital costs of the assets of the business, including those used indirectly to produce the product. These latter costs may include the assets of corporate services areas.

The method of allocation of fixed costs will estimate which proportion of the fixed costs may be attributable to the project. The simplest method relies on allocating a certain percentage of fixed costs to products based on the level of direct costs. However, rarely do products incur fixed costs in set proportions, and this method fails to identify how much of the fixed costs are attributable to the product. The best method is to make an estimation of the amount of fixed costs incurred by identifying cost drivers. For example, Activity Based Costing (ABC) allocates fixed costs according to a best approximation of usage. ABC is useful because it provides not only a good estimate of FDC, but also a flexible cost data base for other cost methodologies.

Table 3.2 Treatment of Costs Using Different Allocation Methods

	SRMC	FDC	Avoidable/Incremental costs
Direct costs (eg, direct labour)	Yes	Yes	Yes
Executive costs	No	Yes	No
Rent	No	Yes	Often, but not always
Other overhead costs	No	Yes	To the extent that they are avoided if the activity is not undertaken
Capital costs exclusive to the activity	No	Yes	Yes
Joint capital costs	No	Yes	To the extent that they are avoided if the activity is not undertaken

Source: Productivity Commission

Alternative methods of costing based on short–run marginal cost (SRMC), long–run marginal cost (LRMC) or avoidable/incremental costs are acceptable in some cases in the private sector — such as in cases involving large sunk costs and spare capacity. These methods generally differ in terms of the size of the increment of demand (marginal cost is the smallest increment of demand while avoidable/incremental cost is generally larger) and in the time horizon considered (short vs. long).

The Productivity Commission has recommended that, for the purposes of competitive neutrality, government business activities should generally seek to recover their FDC (ideally using a method such as ABC). However, they have also recommended that an avoidable/incremental pricing approach can be acceptable for specific products or services under certain conditions.

3.5 Implementing Reforms in Government Services

With attention increasingly being focused on finding the best use of resources to deliver more or superior government services, the Prime Minister, State Premiers and Territory Chief Ministers agreed to establish the Review of Commonwealth/State Service Provision in July 1993. In its report, *Implementing Reforms in Government Services 1998*, the Steering Committee for the Review develops a set of checklists covering practical issues that arise once a government has decided to implement reforms to its services. These checklists seek to cover issues relating to improving the efficiency and effectiveness of service delivery, as well as addressing distributional effects and short-term adjustment costs and are summarised below.

Timing Program Implementation

Implementation options range from pilot programs to test the effect of a reform, to staged implementation of reforms, to full implementation in the shortest possible time frame. In assessing the options for implementation, governments need to balance the benefits and costs of reform, taking into account practical considerations such as the level of resistance to the reforms, the adequacy of available information concerning the likely effects of the reform, and expected adjustment costs.

Decentralising Decision Making

Decentralisation commonly involves shifting responsibility for decision making about the provision of particular services to the lowest possible level. The aims of shifting responsibility for decision making within an agency include increasing customer choice, improving the responsiveness of agencies to customers' needs, and reducing the costs to government of providing the service. However, these benefits must be balanced against a government's desire for accountability, consistent quality, equity, and the cost of foregoing any economies of scale in some activities.

Measuring and Assessing Performance

Reforms to service provision increase the importance of effective mechanisms for monitoring performance. Performance indicators are a key accountability mechanism and also provide valuable information on the effectiveness of reforms. Indicators should enable the performance of service providers to be assessed and, when combined with appropriate rewards and penalties, can create the opportunity for redress where substandard performance is identified.

To measure performance more effectively, governments need to be clear about the objectives of performance measurement, clearly identify the aspects of performance that should be measured, and also address a range of practical measurement and reporting issues.

Measuring Quality

Performance indicators covering service quality are needed to remove the temptation for service providers to reduce quality as a way of improving other measurable indicators of performance. However, measuring the quality of government services presents several challenges. The quality of government services can be measured in different ways — for example, in terms of how services are specified (ie, the quality of inputs, processes and outputs); or whether services are *fit for the intended purpose* (ie, whether desired outcomes were achieved).

Quality indicators for many services are as yet relatively undeveloped. Many areas have an

imperative to develop new or better measures, but the benefits of developing a new, potentially ideal measure for a particular service need to be balanced against the additional delay and other costs of such development, especially when this reduces comparability with other services (either of other providers or in other jurisdictions).

Data for measuring quality may also be costly to collect, particularly if great precision is required and there are many important aspects to service quality.

Directly Linking Funding to Performance

One way of supporting monitoring mechanisms with appropriate rewards and sanctions is to directly link funding for service providers to their measured performance. Under such a scheme, improvements in measured performance could be rewarded by maintaining or increasing an agency's funding level. Underperforming agencies, on the other hand, could be penalised with reduced funding.

Issues that arise in linking funding to performance include: clearly defining the government's desired outputs or outcomes; identifying factors that may affect measured performance (including those outside the control of service providers); and ensuring that customers are not significantly disadvantaged where poor agency performance results in reduced funding.

Charging Users

Implementing user charging is another way of introducing incentives for service providers to contain costs and to apportion demand to clients who most highly value the service. Implementation of user charges should involve a transparent rationale for the level and structure of the new prices If this is developed and communicated effectively, it should aid acceptance by users. The introduction of user charging also involves identifying and measuring the costs of the service; determining the desired level of cost recovery; being sensitive to the patients' ability to pay; and choosing whether to implement charges gradually or more rapidly.

4. COMPETITION IN AMBULANCE SERVICES

Key Points

- **This Chapter** — examines the degree to which markets can be used to efficiently provide ambulance services. From a competition policy perspective, the nature of the market is a critical factor in determining whether regulatory intervention is desirable for a given situation and, if so, what type of regulatory instrument is appropriate.
- **Call taking and dispatch** — direct competition between emergency ambulance services, where ambulances compete to be the first to arrive at the scene, is clearly undesirable as it would potentially endanger lives and risk public health and safety. There continues to be a good justification for restricting access to calls made to the 000 emergency number; however, an independent, centralised call taking and dispatch function could facilitate indirect competition between emergency ambulance providers.
- **Emergency** — emergency ambulance services in metropolitan areas are potentially contestable. Contestability may provide a range of benefits in terms of cost and efficiency, without compromising service quality, equity or public confidence objectives. 'Controlled' competition can and should be phased in for the metropolitan area, but only after the further development of standards, performance monitoring and measurement systems, contractual arrangements and a regulatory framework. As a prerequisite for competition, the emergency operations component should be structurally separated from the higher level functions of MAS — general control of the system, setting standards etc. The remaining core of MAS, combined with other elements from RAV and possibly the Department, should be constituted as an authority to perform the roles of specialist regulator/detailed purchaser for the industry. Chapter 5 discusses alternative structural models within which these basic directions of change could be implemented.
- **Rural and metropolitan** — Key differences exist between the rural and metropolitan markets for ambulance services. There are greater opportunities for economies of scale in service delivery in larger and more concentrated populations in metropolitan areas compared to smaller, more dispersed populations in rural areas. Therefore, introducing competition in rural emergency ambulance services is more complex and less likely to result in clear benefits. Moreover, the sector is currently undergoing an amalgamation process. Contestability opportunities should be pursued in rural and regional areas only after lessons have been learned from the initiatives in the metropolitan area.
- **Non–emergency and urgent** — the non–emergency market has always been subject to some degree of competition. A key question is whether there is a level playing field between ambulance services and private contractors. Ambulance services should be free to compete for urgent and non–emergency cases in the inter–hospital transfers market, so long as they conform to competitive neutrality pricing principles. Subsidies for pensioner transport should be directly contestable by private providers and ambulance services. The payment arrangements for hospital patient transport should be reviewed at the same time. To ensure that ambulance transports are not used for non–clinical reasons, improved guidelines should be developed in relation to the authorisation of subsidised pensioner transports. Consideration should also be given to the viability of other mechanisms to deter unnecessary usage. In relation to the issue of standards for the non–emergency industry, a single regulatory framework should apply to both emergency and non–emergency sectors. The regulation should not be overly prescriptive and should rely to the greatest extent possible on reference to industry–developed standards or codes of practice and existing quality assurance processes.

- **Pre–hospital care** — the clinical capabilities and resources of ambulance services can clearly be used within the broader health sector especially in rural areas. The corporatisation of ambulance services would allow them to focus on core competencies and pursue additional activities that are complementary to their skills and resources. If ambulances are to be used to deliver mobile out–of–hours medical services, then they should be funded to do so or more effective alternatives considered.
- **Training** — training in the occupations required to deliver ambulance services should be managed under the same general framework as applies in broadly comparable areas, with the industry — and the regulatory authority for ambulance services — having a key role in setting standards. Ideally, such arrangements should be pursued at a national level with all major sections of the industry having representation. The Government would need to construct the future purchasing framework in such a way that necessary on–the–job experience is accessible to employees of all service providers.
- **Subscriptions** — in a competitive environment, the combination of non–actuarially determined subscription rates and a seemingly strong 'brand' may provide a significant competitive advantage to the incumbent ambulance services in operating a subscription scheme. In the case of a move to a competitive environment, consideration should be given to the option of a single state–wide subscription covering public and private providers and overseen by an independent regulator/purchaser.
- **Emergency management** — is a key role for ambulance services. The main concern for this review is whether emergency management objectives can effectively be met under a competitive model for emergency ambulance services. Emergency management objectives appear capable of being met through licensing and contractual mechanisms.

4.1 Overview

As already noted, this review has two main elements:

- To examine the case for reform of specific restrictions on competition contained in the Act.
- To make recommendations about legislative reforms that will improve the quality, responsiveness and efficiency of ambulance services.

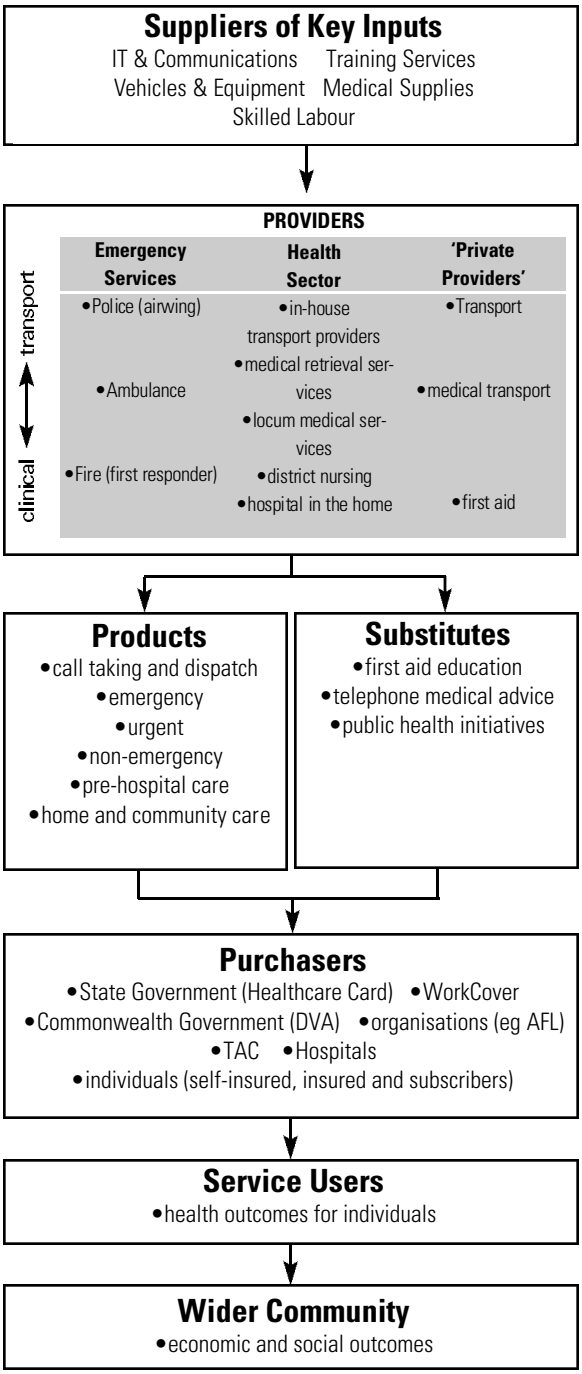
The aim of this review is essentially to examine competition issues in the context of a future legislative framework designed to deliver quality, responsive and efficient ambulance services that are integrated with the broader health and emergency services sectors.

Legislation for heavily regulated industries like ambulances services includes restrictions on competition. Such restrictions may have been put into place to secure some public benefit, but they can often have the effect of reducing efficiency, innovation or service quality. However, before discussing competition issues in relation to ambulance services, it is important to make clear that the purpose of competition policy reviews is not to promote 'competition for competition's sake'. Rather, the aim is to assess whether, and to what extent, competition can be used to enhance outcomes. In the case of ambulance services, a completely unregulated market in which providers compete on the streets is clearly both undesirable and unworkable. Competition should also not put at risk the significant benefits from community engagement, especially for smaller rural communities. Competition and cooperation are not mutually exclusive. The real challenge is to establish more competitive arrangements, where appropriate, which preserve and extend the benefits of community support and cooperation.

This Chapter will examine the degree to which markets can be used to efficiently provide ambulance services. From a competition policy perspective, the nature of the market is a critical factor in determining whether regulatory intervention is desirable for a given situation and, if so, what type of regulatory instrument is appropriate.

Clearly, what constitutes the market will vary with the service being examined. Ambulance services can be seen as part of a broader market that includes medical transport and mobile medical services, as depicted in Figure 4.1. In a sense, this market is divided into a number of sub–markets which may be substitutes for each other to a greater or lesser degree. The remainder of this Chapter examines issues surrounding the contestability of each individual service and some issues that cut across a range of services.

Figure 4.1 Overview of the Supply of Medical Transport/Mobile Medical Services



4.2 Communications, Call Taking and Dispatch

Issues

The call taking and dispatch function receives requests for services from the public, and schedules a response to requests. Access is through a single '000' number, currently operated by Telstra, who route the call to police, fire or ambulance services. In an emergency response, it is critical that the time taken from receipt of a call to the dispatch of an appropriate vehicle is minimised. Ensuring the public has access to a fast response call system increases the likelihood of improved health outcomes to people requiring assistance. The requirement for a timely, efficient and coordinated call taking and dispatch function, provided within an appropriate quality assurance framework, leads to a conclusion that, at any one point in time, there can only be one provider of this function for a particular area. That is, there cannot be direct competition between two or more call taking and dispatch businesses, as multiple providers would lead to fragmentation at the front end of the State emergency response.

Once a call is received, the call taking function quickly determines the location and status of the incident. The dispatch function generally maintains a record of the location and response status of all operating units and then dispatches the closest appropriate resources. Traditionally, experienced ambulance officers have usually undertaken these functions, and relied on guidelines and operational experience to determine priorities and the appropriate response. More recently, systems have been utilised whereby a trained 'civilian' operator asks a caller a series of pre–determined questions, resulting in a response dependent on the answers to those questions. These 'protocols' are carefully constructed based on clinical and operational analysis to minimise overall dispatch time and ensure an appropriate response. The scope for individual judgement by the operator is significantly reduced. A clinical review process is conducted by experienced senior operational personnel to ensure adherence to call taking protocols for emergency calls involving ambulance dispatch.

Call taking and dispatch in non–emergency work is different to emergency in that the primary emphasis is on effective capacity utilisation rather than availability, such as in efficiently coordinating the transport of multiple patients from varying locations using the least number of vehicles. However, it is not exactly the same as the call taking and dispatch function of, say, a taxi company, because the clinical status of the patient needs to be matched with the appropriate vehicle type and patient carer capabilities.

There are economies of scale in the communications, call taking and dispatch function, particularly when employing computer aided dispatch (CAD) technology. Economies revolve around the large investment required in communications, information systems and facilities, and the need to staff services for peaks, to ensure that the probability of congestion of emergency calls is minimised. Facilities may be shared by different emergency services. The high speed and reliability of telecommunications mean that the function can be located far from the caller, so that very large call areas may be practical. However, since a fail–safe option is required in the event of an entire facility going down, each communication service must also have an immediate back–up capacity, as is currently the case in the metropolitan area.

The metropolitan area is in fact serviced by a private provider, Intergraph, which covers police, fire and ambulance services (along with the Victoria State Emergency Service). An outsourced CAD function has been implemented on a whole of government basis, administered through the Bureau of Emergency Services Telecommunications (BEST) in the Department of Justice. There were transitional problems in designing and administering such complex arrangements but these are now in the past. A centralised CAD system is also being proposed to cover the rural ambulance services.

Stakeholder Views

- MAS noted that the existing out–sourcing arrangements for call taking and dispatch are now well established. It argued that the case for centralised emergency call taking and dispatch in Melbourne is very strong on grounds of both operational efficiency and cost. It pointed out that initial steps towards further integration of the system with other emergency services have been taken as part of the First Responder pilot project with the MFESB. It argued that any further integration would need to be carefully managed given the differences in requirements of the different agencies.
- With regard to non–emergency dispatch, MAS noted that there may be financial advantages in using a less technologically advanced system, and/or transferring more of the responsibility for dispatch functions to the direct service provider. However, it argued that provision of both emergency and non–emergency call taking and dispatch by a single contractor facilitates operational flexibility in handling the boundary between emergency and non–emergency work, and that this promotes efficient resourcing. In its view, a decision to separate emergency and non–emergency call taking and dispatch should be based on detailed operational and commercial analysis.
- Rural ambulance services in general supported a single centralised CAD system for rural Victoria, which could be outsourced to a private provider. Some were of the view that it should cover both emergency and non–emergency work, whilst others considered that non–emergency work could be opened up to multiple providers. A number noted that there was a clear potential for conflict of interest where the dispatcher was also one of the providers of ambulance services.
- Ambulance Employees Australia, Victoria Branch (AEA–V) believed that call taking and dispatch was one of the core components of an ambulance service. It noted that international best practice trend was towards homogenous and centralised ambulance services, and that any unbundling of the function (including the current contracting out) would not be in the public interest.
- A number of stakeholders supported uniform systems of communications, call taking and dispatch for emergency calls that were integrated with other emergency services. This is to take advantage of economies of scale and also because a uniform system is a pre–condition for effective competition in

emergency ambulance services. There was a view that the communications and call centre industries were rapidly growing and becoming increasingly sophisticated. It was considered that emergency work should be seen as one segment of this market because communications, call taking and dispatch services are likely to be available competitively from a number of suppliers.

- A number of stakeholders supported the separation of the call taking and dispatch role from the ambulance services, noting that there would be clear conflicts of interest in the provider of the dispatch function also providing ambulance services. Victorian Patient Transport Pty Ltd (VPT) argued that an independent regulator should be responsible for setting the standards required in emergency call taking and response, providing the clinical presence currently supplied by MAS, and monitoring and auditing the performance of the call taking and dispatch supplier. VPT believed that non–emergency call taking and dispatch would be most efficiently operated by individual providers, while some other private providers were keen to have access to a central call taking and dispatch system.
- A very wide range of stakeholders noted the importance of maintaining public confidence in relation to the call taking and dispatch function, and many stated that any changes should be very carefully implemented to avoid possible public confidence problems.

Conclusions

Whilst a distinct and separate component of the overall service, the call taking and dispatch function is clearly integral to ambulance operations. The quality of the dispatch process is a key determinant of overall operational efficiency and effectiveness. It is also important that there is effective communication between different dispatch functions, such as the metropolitan and rural services, in order to efficiently use resources and minimise border problems.

The requirements of call taking and dispatch can be specified, and tenders called to supply the service for a specific time period. While there seems little scope for direct competition, competition for a contract to undertake the service for a period appears to be viable through periodic re–tendering. There is now a considerable body of experience which could be drawn upon in that context.

If competition is to be introduced, there would be clear potential for conflict of interest if the dispatch process were controlled by a provider who was also a supplier of ambulance services. This suggests there is a role for an independent regulator/purchaser in providing the call taking and dispatch system. Even if competition was not introduced, this would also place the regulator/purchaser in a good position to be a well informed buyer and to consider the benefits of greater integration with other emergency services.

An independent regulator/purchaser should be responsible for providing centralised emergency call taking and dispatch functions separately from the operational elements of MAS and Rural Ambulance Victoria, and these services could be sourced through periodic competitive tender. All 'licensed' emergency ambulance providers would be required to use the system, and should collectively have input into its design and administration. For this model to work, there would need to be very close cooperation between the regulator, the communications provider and the ambulance providers.

The need for centralised call taking and dispatch to also cover non–emergency is less clear, but an independent regulator/purchaser (who is also a major purchaser of non–emergency services for Healthcare card holders) would be well placed to make such judgements between cost and flexibility of response.

Such initiatives seem unlikely to undermine service quality or equity and access objectives because they provide government with a much greater ability to directly specify and monitor outputs and inform its role as purchaser and regulator of ambulance services. Primarily, this change would involve moving resources and roles that already exist into a new body. As such, it is unlikely to raise overall costs, although there may be some additional coordination and communication expenses.

Recommendations

- An independent regulator should be responsible for the provision of centralised emergency call taking and dispatch functions, but could contract out the service provision. Competition for this contract is likely to improve the quality of the dispatch function, thereby helping to enhance the overall operational efficiency and effectiveness of ambulance services.
- These functions should be separated from the operational elements of MAS and rural ambulance services.

4.3 Emergency

Issues

The emergency response is the core requirement of an ambulance service. The service can be seen to include three key components:

- *A clinical function*—to be able to assess the emergency pre–hospital needs of the patient and administer the necessary first aid or pre–hospital care with the aim of treating or stabilising a patient either at the site or en–route to a medical facility. This function relies on skilled patient carers, medical supplies and equipment and communications systems.
- *A transport function*—to move rapidly to the scene and to transport a potentially critically ill, usually stretcher–borne, patient rapidly from the scene to a medical facility, while maintaining the highest degree of safety in transit. This function relies on specially designed vehicles, skilled officers and communications systems.
- *Major incident/disaster preparedness*—availability, in concert with other emergency service organisations, to attend major incidents/disasters.

There are a number of operational challenges in providing an emergency response. For example, while overall patterns of demand for the service can be projected, incidents cannot be accurately predicted. Consequently, the operator must deploy resources to provide for the greatest probability of meeting the response time, transport and clinical needs of the patient.

Another challenge is that, in order to provide a high degree of availability in the case of a major disaster or multiple emergencies occurring at the same time, there is often significant downtime or spare capacity, particularly in rural areas. Perhaps one of the most important challenges is that emergency crews are often called to work in difficult and sometimes extreme environments managing relatively unpredictable situations As a result, crews operate with a high degree of autonomy and decision–making flexibility.

Is the emergency response 'market' contestable? Direct competition between emergency ambulance services, where ambulances compete to be first to arrive at the scene, is clearly undesirable as it would potentially endanger lives and risk public health and safety. There are also public confidence issues to consider, since the public will expect a certain standard of service in response to an emergency call. There appears to be a strong case for some central coordination of the deployment of ambulance resources to ensure that the response effort is optimised, given the unpredictability and the seriousness of emergency response work. In addition to the ethical and social concerns, a sub–optimal emergency response could also result in significant 'external' costs through flow–on impacts on health outcomes. Central coordination might cover such issues as operational, dispatch and communications protocols, vehicle and equipment specifications and clinical standards.

However, like the call taking and dispatch function, it is possible to envisage that elements of the emergency response could be contracted out to other providers to undertake work under central coordination using established protocols and standards in a similar fashion to current practice. In fact, a small example of such an arrangement already exists within the MAS in the Cranbourne area. The Cranbourne station operates under the same regime as other MAS stations, except that the officers as a group have a contract with MAS to perform the service. Some describe this more in the nature of a workplace agreement than a competition model, in the sense that it relies on the full resources of the MAS. However, it does allow for some risk sharing and provides some incentives for efficiency gains. The operational performance of the station and the

level of community support have been high. A model where a central body sources and provides a range of sub–contracted support services to a series of Cranbourne–style contractors seems potentially viable.

If a contractor were to provide a stand–alone service, the size of the business may not need to be large to achieve economies of scale in such areas, particularly if it can contract out services such as fleet management and maintenance, equipment maintenance and communications. Internal operational units within MAS have varied in number over the 1990s from three to the current six. This may provide a rough guide as to the number of different operators that may be able to service the metropolitan market on an efficient scale.

The current legislation contains restrictions on competition as it effectively provides for regional monopolies and price controls for emergency response to the existing ambulance services. In addition, there are restrictions contained in other Acts and regulations in relation to road safety, the use of lights and sirens and the administration of certain drugs.

A notable exception to this monopoly is the armed forces which have well developed 'ambulance services' in the form of armed services medics which are closely integrated into the armed services hospital services.

Private 'ambulance' services currently provide first aid and 'on course' transport services at sporting events such as horse racing, motor racing and football, and at film shoots, on a commercial basis subject to conditions set by the auspicing body (eg, Racing Victoria or AFL). However, ASV ambulance services are generally used in emergency situations where it is necessary to transport a patient 'off course' to a hospital.

In the past, private operators have proposed providing emergency services. However, the supply of the necessary skilled labour has been an important constraint and they were not able to gain access to clinical placements on emergency ambulances. Private medical transport firms could conceivably provide wider emergency services at some point in the future. There are also a number of large private ambulance operators in the US (as discussed in Section 2.5). Furthermore, a range of medical retrieval services are already operated by hospitals, although most use some ambulance service resources.

An alternative view of contestability is to consider at least the partial unbundling of emergency response effort. Most of the transport element of the state–wide air ambulance service is already outsourced to a private operator who is responsible for providing aircraft, aircraft maintenance and pilots (although in the case of some helicopters, pilots are provided by the police), but not patient carers. On the ground, it may be viable to consider the use of single paramedic flying squads in cars backed–up by a stretcher transport function as necessary.

In a small way, this concept is already being tested in the eastern and south–eastern suburbs of Melbourne under a pilot 'First Responder' program whereby MFB and ambulance units are simultaneously dispatched for certain case types. The aim of the pilot program is to test whether this approach can result in improved response times and patient outcomes in very time–sensitive cases — in particular, heart attack victims. The pilot program is not in contravention of the Act, given that MFB is involved only in provision of mobile clinical services, and not medical transport. There are already a number of providers, other than MFB, who could potentially provide either an unbundled clinical or transport function. A number of other elements of the emergency response effort are already outsourced — for example, fleet management has been outsourced by MAS.

An important issue when considering the role of ambulance services is that one of the functions of emergency services is to plan for, and respond to, major disaster situations. In this respect, one industry stakeholder commented that 'you don't design an army for peacetime'. The competition policy implication is that an industry structure and regulatory framework that is designed to promote contestability in day–to–day situations may, in extraordinary circumstances such as major emergencies, reduce the capacity of the emergency response effort at a time when it is needed most. The areas of concern might be the existence of reserve powers, a command and control structure,

high level of integration of different service elements and common standards and training.

There are also a number of important questions in terms of the demand for emergency ambulance services that need to be considered. The legislation requires that ambulances simply "respond rapidly to requests for help in a medical emergency" (section 15). Demand has grown considerably in recent years, especially in the metropolitan area, and this has been at a greater rate that would be expected from population growth or demographic changes. This may be due to the broader changes in the health sector such as deinstitutionalisation, the increasing emphasis on home and community care, and the decline in GPs' willingness to undertake home visits after hours — there is evidence of increased usage of ambulance services as effectively a 24 hour locum medical service. The increase in demand may also be due to changes in welfare expectations in the community: people may increasingly see emergency ambulance services as a service that the community has paid for (through their taxes), and to which they have clear entitlements, rather than an emergency function which should be reserved for those in the greatest need.

In competitive markets, pricing generally provides a good signal of the value of a service so that it is not over– or under–utilised. For ambulance services, a large segment of users do not face any direct costs in using the service (eg, Healthcare card holders). In terms of managing demand, it may be useful in these cases for users to directly bear a proportion (possibly small) of the value of the service, especially in the cases of obvious abuse of the 'free' service. On the other hand, for those in the community who are not in a state to clearly understand their own medical condition (for example, people with certain mental or intellectual disabilities) or who cannot afford expensive private services, a pricing approach of this type may not be appropriate.

The answer may be to provide in other ways a 24 hour medical service for such members of the community, or to allow ambulances the option of transporting patients to local extended hours clinics, rather than just hospitals. This option may, in fact, support the viability of such clinics. If such services are to be provided, the question arises about who is to pay for them. It may well be that the cost is rather less than the cost of increased use of ambulance services to substitute for them.

These 'demand side' issues clearly have important implications for competition because they help define exactly what services ambulances provide and help suggest ways in which this may be done more efficiently.

Rural and Metropolitan Differences

It is important to acknowledge a key issue in the major differences that exist between rural and metropolitan markets for a range of services, including ambulance services. Larger and more concentrated populations in metropolitan areas provide for economies of scale in service delivery compared to smaller, more dispersed populations in rural areas. This is particularly important where there are large increments of supply and/or fixed costs are relatively large compared to the size of the market.

For example, the workload in much of the metropolitan area is sufficient to justify a dedicated emergency response function with a relatively high rate of utilisation. In comparison, providing around–the–clock, two–officer (on duty/on call) crewing in a small town requires, on average, a complement of five to six officers and dedicated vehicles at significant cost, but there may be only a few emergencies per week.

Similarly, the unit cost of providing a permanently staffed, stand–alone emergency service in the smallest towns can also be high. A major challenge for providers of ambulance services in regional areas is how to utilise spare capacity without compromising the ability to provide the core emergency response service.

Other challenges in providing ambulance services in rural areas are skills development and maintenance, attracting and retaining preferred staff and a range of related lifestyle and social issues, such as boredom, health implications, the on–call nature of rural work, work and schooling opportunities for partners and children of officers.

On the other hand, rural services provide highly satisfying work opportunities for many officers, and generally provide greater scope for a high level of community involvement in the local

ambulance service, including attracting suitable volunteers for training as casual officers, fund raising and other support activities. These challenges are not altogether unique to ambulance services, but in many respects are shared with providers of a range of other emergency or human services. Innovative solutions to the challenge of delivering high quality human services at a reasonable cost can involve the sharing of resources, closer cooperation, co–location and increased integration of service providers and a greater engagement with the community.

Stakeholder Views

Metropolitan Ambulance Service (MAS)

- There has been extensive contracting out of ambulance support services and service delivery in Melbourne, based on competitive tendering processes. The MAS now relies on the private sector for the provision of call taking and dispatch services, non–emergency stretcher transport, fleet management and maintenance, aircraft operation, information technology, subscription scheme operation, equipment maintenance and a number of other services. The outcomes of contracting out have been detailed in the Auditor General's Special Reports Nos. 49 and 50. Emergency ambulance response is the only major service still provided by in–house resources in Melbourne. Any further transfer of service provision to the private sector should be subject to a rigorous analysis of the costs and benefits on a case–by–case basis.
- The most appropriate means of delivering emergency services is through a single public entity. Emergency ambulance response is an essential service, and the community rightly has a very low tolerance for service behaviour. Clear lines of accountability are critical to public confidence in the system. Dividing responsibility for service delivery can only serve to diffuse responsibilities and undermine accountabilities. There are significant coordination issues and economies of scale in the delivery of emergency services that favour a single provider. Coordination issues are of particular significance in response to a major disaster.
- Contracting out to a single private provider could introduce serial competition, but would be likely to create an effective private monopoly. Management of the contract would introduce another layer of costs and there is a risk that vertical integration issues across the hospital sector would arise. The risk of financial failure of the contractor could be minimised by appropriate processes, but the consequences could be catastrophic.
- Geographic franchises would introduce inherently inefficient boundaries, duplication of administrative costs and unnecessary system complexity. The potential financial failure of a franchisee would also introduce new risks to the continuity of service delivery.
- Independent service providers could in theory be coordinated via the call taking and dispatch system, but such an approach is fraught with the potential for conflict and failures of communication. The central control required would undermine potential benefits from competition.
- With regard to the options for 'unbundling' of services raised in the Discussion Paper, MAS noted that most of its support services are already unbundled and subject to tender. An increased role for its first responders is expected in the future, although this only represents a very small component of emergency ambulance service delivery (approximately 2.5%). Community responders should also be encouraged. To be fully effective, first responders must be coordinated with the delivery of higher level skills and patient transport capacity. Compatibility of training and equipment are also critical. A single emergency ambulance service provider should take the lead role in response and coordination.
- MAS also deploys some MICA paramedic single responders, effectively unbundling clinical and transport services. These units can be very effective in some circumstances (eg the central city), but they require a minimum three officer dispatch with inherent higher costs than the conventional two officer dispatch, and may fail to provide for patients requiring rapid transport. Deployment decisions should be based on detailed analysis of the options, and this is best undertaken by a single service provider
- Sub–contracting of service delivery along the lines of the Cranbourne model is workable, but system integration issues would need to be carefully managed. Sub–contracting is essentially an alternative means of employing staff. The key to successful extension of the sub–contracting model would be the support of existing MAS staff.

Rural Ambulances Services

- Unbundling of the emergency effort, such as through a first responder model, is not generally suited to the lower population densities of regional and rural areas other than in a few high density pockets.
- It was considered there is only room for one emergency ambulance service in any given geographic area, and perhaps even throughout all rural Victoria. In fact, even with one ambulance service, they would still generally need to undertake non–emergency work to fill down–time and to reduce the overall cost of the service.
- Emergency response by private contractors was thought by some to be feasible under certain conditions, with oversight by an independent regulator. Others thought that there were risks to service quality from private contractors, particularly for less profitable rural areas. Some also thought the privatisation of ambulance services would not generally be acceptable to communities, especially smaller rural communities, and could be counterproductive in terms of encouraging volunteers and other forms of community engagement.
- Most agreed that there are substantial gains to be made from closer integration with local health or emergency services organisations, but the synergies with the health sector are greater.
- An independent specialist purchaser/regulator of ambulance services, separate from the provider, would generally be welcomed.

Other Providers of Patient Transport

- Victorian Patient Transport Pty Ltd (VPT) made a strong distinction between major regional centres and other rural areas, noting that major regional centres were more akin to the metropolitan area and metropolitan fringe areas were more akin to rural areas. It stated that, in the longer term, the private sector was potentially capable of delivering high quality and efficient non–emergency services and emergency services in the metropolitan area, and non–emergency services in rural and regional areas. VPT believed that competition should be introduced first to the metropolitan area, and should ideally be limited to a single major private provider in full competition with MAS under the oversight and audit of an independent regulator. The regulator would play a central role in setting standards and monitoring performance. Properly constructed contractual mechanisms for emergency were thought to be an excellent way of providing increased accountability for performance. The larger private providers were capable of gearing up relatively quickly to provide emergency ambulance services. The unbundling of the emergency response in urban areas into MICA paramedics, primarily for emergency response, and ambulance paramedics, primarily for emergency transport, was seen as viable and efficient. In rural areas, the approach of the Tasmanian Ambulance Service outside the metropolitan area provides a good model for community engagement and the use of a mix of volunteers and professional staff to provide a cost effective and reasonable quality service.
- St. John Ambulance believed that a more transparent and effective system would benefit Victorians with a dismantling of the current closed loop support for government monopolies. Benefits to the public would be improved by provision of services by community agencies supported by subsidies to achieve certain outcomes and contracted suppliers, networked to enable coordination. Regional geographic franchises with porous boundaries are viable, but central call taking and dispatch, clinical audit and funding should be best unbundled from the contracts and overseen by a light–handed regulator.
- Patient Transit Care believed that the metropolitan area could be divided into five areas serviced by private contractors, with fire services providing MICA paramedics from fire stations in rapid response vehicles. Oversight of deployment, QA and clinical standards by a body with overall control would be required. Most current private providers have the necessary skills and resources to undertake emergency work, and contractual mechanisms could provide for lower cost and greater quality of service.
- Home Care Patient Transport said that emergency private transport back–up to a paramedic flying squad is currently achievable, and more extensive emergency private services are possible with an adequate lead time and funding. The skill set for first responder emergency services is different to that of interhospital and other non–emergency services, but such skills are purchasable, maintainable and trainable in the private sector. The public interest is best guarded by adequate and transparent quality assurance and quality improvement activities, whoever provides the service.
- Medical Transport Services (MTS) has provided ambulance services at public events, for the Neonatal Emergency Transport Service, as agency staff and for major emergencies. In its experience, contractual

arrangements have not compromised the emergency response effort, although its experience is limited. An extension of the current MAS system to include contractors as part of the response team (secondary response) would be unlikely to compromise the effort of primary response.

- Ambicare Patient Transfer believed that there was significant benefit to be gained in rural areas in setting up 'mini' ambulance stations and in closer integration with the hospitals with an emphasis on casuals and first aid training. This could be provided by the private sector.
- Ambikab Western Region argued that non–emergency sub–contractors to MAS were able to install 'lights and sirens' and that this constituted an unfair competitive advantage over other non–emergency providers when using the same vehicles to tender for other non–emergency work. Non–emergency vehicles should be able to use lights and sirens under certain circumstances, such as in the case of a patient whose condition deteriorates to urgent/emergency status during transit. Restrictions on the word 'ambulance' are unnecessary and can result in unfair competitive advantages in non–emergency work.

The Health Sector

- The Inner and Eastern Health Care Network noted that there were likely to be advantages in changing from a monopoly situation to one of multiple providers of emergency ambulance services in relation to service innovation and efficiency. However, potential disadvantages were in the form of equity issues, service integration, disaster planning response and transaction costs. Further evaluation of the relative merits of different contestability models is required. Legislative reform should aim to strengthen the purchasing role with priority attached to quality monitoring, the development of output based funding mechanisms and systems integration. Legislative reform may also involve the establishment of a separate purchasing entity at arm's length from government; however, Ministerial and Departmental oversight should be retained during the transitional stage. An implementation sequence was proposed — in particular, service quality benchmarks must be agreed and established well in advance of any major reconfiguration of ambulance services.
- The Southern Health Care Network believed that it would be possible to achieve a degree of competition in the metropolitan area for ambulance services, albeit with providers needing to cooperate and coordinate their activities. They have direct experience with the Cranbourne station and noted that their operational performance and the level of community support for the station have been high. The Network also supports the current First Responder pilot program with MFB and is also trialing the concept of emergency nurse practitioners. It is its opinion that there ought to be the ability to introduce "controlled competition" in the emergency response in the metropolitan area, without compromising operations with public and private providers competitively tendering to undertake various elements of an integrated emergency response effort. Staged market testing and transitional arrangements could be undertaken.
- Metropolitan hospitals had a wide range of views — from cautious support for contestability of emergency responses, to support for the current arrangements. The Alfred Hospital was concerned that any changes resulting from the introduction of competition should not reduce service quality, noting that a range of quality improvements to the current arrangement were possible. It believed that service improvements should be driven by high quality research data and quality audits. The Alfred Hospital also sought a formal and a broader role for medical retrieval under the Act. The Epworth Hospital argued that emergency cases should remain in government hands and be centralised.
- Rural and regional health services and hospitals also had a range of views. A common theme was that the integration and fostering of alliances between local ambulance facilities and health agencies in rural areas has the potential to deliver considerable gains to the rural community. Concerns were raised about access, equity and quality of service issues in rural areas, and a fear that competition and economic drivers could impact negatively on the services. Others believed that there was scope for private contractors to provide services in rural areas with proper oversight and accreditation.

Major Buyers

- The Traffic Accident Commission (TAC) believed that fragmentation of the service should be avoided and did not support the introduction of multiple emergency providers.
- The Workcover Authority noted that emergency was not a huge priority for them as they has less of a trauma case–mix profile than TAC but shared some of TAC's concerns regarding fragmentation.

- The Department of Veterans Affairs (DVA) argued there were perceptions of an inadequate skill base in the private sector and DVA would adopt a cautious approach in the absence of recognised industry accreditation of emergency providers. DVA was also concerned that if fragmentation were taken too far, it would run the risk of jeopardising the organic whole.
- Racing Victoria claimed that existing legislative restrictions on competition in the provision of emergency medical transport services should be removed to the extent necessary to permit licensed private operators to contract directly with end users to provide emergency medical transport services not involving centralised response/dispatch. It strongly supported the application of the purchaser–provider model and contestability under an appropriate regulatory framework.

Other Emergency Services

- The Metropolitan Fire and Emergency Service Board (MFSEB) believed that the Discussion Paper raised a number of basic questions that would seem to require major studies if quantifiable responses were to be made rather than qualitative assessments. It pointed to the difficulty of assessing costs and benefits in emergency services. MFESB identified a range of contractual difficulties that private tenderers might face and highlighted industrial relations as a major issue. MFESB noted that the issue of privatisation of firefighting operations was raised some three years ago in a report to the Board by KPMG. Nevertheless, the Government has endorsed the Board's recommendation to proceed on the basis of developing accountability and transparency through business units and improved services in community safety, and this is reflected in enterprise bargaining negotiations with staff.
- The Country Fire Authority (CFA) is in a strong position to explore further integration/cooperation particularly with the rural ambulance service, and emphasised the importance of community involvement and volunteer contribution. Legislation will need to be flexible enough to support, encourage and facilitate locally driven, community based safety solutions. The economic and administrative benefits flowing from contestability must be assessed against the broader social and community engagement perspectives.
- The Victorian State Emergency Service (VICSES) was interested in exploring a first responder cooperative arrangement in rural Victoria.
- The Bureau of Emergency Services Telecommunications (BEST) believed that the introduction of a private sector provider of a multi–agency call taking and dispatch service has created the environment for further private sector involvement in the delivery of ambulance service in a competitive environment. Two service providers could undertake the delivery of emergency ambulance service in the current MAS response area and probably beyond. The infrastructure for monitoring the performance of the delivery of emergency ambulance service by these providers through the database provided and maintained by the private sector service call taking and dispatch provider is in place. MAS should not be both purchaser and provider. Without the introduction of competition in the metropolitan area, it is unlikely that any further reduction in response times will be achieved without the continuing call upon Government for additional resources
- The Department of Justice noted that opportunities for synergies should continue to be exploited regardless of who provides the ambulance service.

Other Stakeholders

- The AEA–V argued that there is no demonstrable benefit to be derived by the community from the privatisation, unbundling or contracting out of all or some of emergency, urgent or non–emergency work. This is true for call taking, dispatch, response, treatment, initial/interim triage, management (fleet and employees), and transport. The creation of unnecessary barriers between the core components of an ambulance service severely impacts on the efficiency and effectiveness of the service. Reliance on legalistic contractual enforcement and business principles is contra–indicated for ambulance services which are not easily subject to performance/value measurement. A number of privatised and contracted out components have not only been financially more expensive, but the effectiveness of the service has been diminished and public confidence has been eroded.
- The Ambulance Officer Training Centre (AOTC) believed that there is no evidence of enhanced outcomes from competitive tendering for emergency ambulance services. It claimed there are potential disadvantages and, without any evidence to support the benefits of change from the perspective of efficiency, equity and access on a state basis, the

provision of emergency ambulance services should remain as a public agency. The AOTC was not aware of any examples of multiple emergency service providers competitively operating in the same city or county in the UK, USA or Canada.

- A number of community groups were also concerned about the impact of private sector provision of ambulance services on access, equity and service quality, especially in rural areas and particularly on the more vulnerable members of the community. They were sceptical of the ability of community engagement to be sustained under a private provider. They did not support the idea of a co–payment for pensioners. The Victorian Community Advisory Group on Mental Health raised the issue of the need for ambulance service calls for mental health service requirements rather than a police response.
- Submissions were received from a range of individuals, primarily from people associated with ambulance services. Most were highly critical of the likely benefits the unbundling of the services and the introduction of competition in the emergency ambulance response.

Discussion

Potential contestability of the emergency ambulance response is the major issue involved in this review. Direct competition between emergency ambulance services is clearly not in the public interest. While virtually all stakeholders recognise that the emergency service could potentially be subject to controlled competition, there is disagreement on whether this will result in a more efficient and equitable service. Given the risks involved, many of the major stakeholders believe that a cautious approach is warranted. In addition, there is a strong view amongst stakeholders that the issue of competition needs to be dealt with differently in the metropolitan area compared to rural areas.

The Cases For and Against Competition

The case in support of the introduction of competition rests on the proposition that government monopolies have inherent problems, and that alternative regulatory instruments could potentially be used that are more efficient, allow for greater competition and would also support the Government's broader equity and policy objectives.

The case in support of a government monopoly is somewhat more complex, and appears to rest on a number of propositions:

- The government's equity objectives may be compromised in a competitive environment.
- The economies of coordination, scale and scope favour a single provider.
- The performance and quality assessment and the regulation of standards of private providers are problematic, costly and risky and best delegated to a single government provider.
- The theoretical benefits of competition may not be achievable in practice due to the nature of change processes and workplace relations.
- The emergency ambulance response is a highly sensitive area, competition reforms are not popular and reforms may risk damaging public confidence.

This part of the report will examine these arguments in turn in light of the available evidence. The discussion will draw heavily on concepts outlined in Chapters 2 and 3.

Merit Goods, Public Goods and Externalities

A number of stakeholders have argued that ambulance is either a public good, a merit good or is characterised by *externalities* and that this justifies public provision (see Section 2.2). Ambulances services are not a 'public good', as it is clearly possible (in theory) to exclude people from the service. Rather, ambulance services should be seen as a merit good in that exclusion on the basis of inability to pay would not meet community standards. Moreover, exclusion may also result in broader social (or external) costs being incurred by the community, such as health costs, loss of output and an adverse impact on families. Ambulance services are often the first link in a chain of response to an acute health care episode. The delivery of an efficient service can provide significant benefits to the patients themselves but will also have additional advantages in the form of reduced costs in the rest of the chain and in the broader community. Virtually all stakeholders agree that there is a role for government in funding aspects of ambulance services, however, it does not follow that it should exclude private provision of certain aspects of such services. Indeed, there may be cases where

private sector involvement can be expected to result in improvements in service quality.

It is important to note that the existence of significant externalities can be an argument for government providing funding or subsidies, but, once again, it is not necessarily an argument for government service provision. As long as contractual and regulatory mechanisms are adequate, then subsidies could be provided to private or public sector providers, as currently applies in the case of non–emergency stretcher services.

Monopoly Government Provision and Economies of Coordination, Scale and Scope

As noted in Chapter 3, government provision is essentially a form of regulation, and there is a series of well understood problems associated with government bodies delivering services. A number of stakeholders (including some ambulance services) have made comments that, in their view, aspects of these phenomena have been present in ambulance services.

In addition, ambulance services are effectively *legislative monopolies*, and monopoly structures are not conducive to efficiency except in a number of special cases, such as natural monopoly. A natural monopoly is where the economics of supply (such as economies of coordination, scale and scope) are such that it is only efficient for there to be a single supplier in a given market.

Emergency ambulance services are clearly characterised by *economies of coordination*; emergency events are largely unpredictable, rapid response is often crucial, and the deployment and use of one resource affects the optimal deployment and use of other resources. However, as discussed earlier, the economies of coordination are mainly concerned with the requirement for a single centralised call taking and dispatch system. Given such a system, it appears viable to have a number of different response resources within a given area that are potentially owned and operated by different parties. Indeed, such a system already exists on a smaller scale in terms of the First Responder pilot and the use of non–emergency resources for some lower level emergency cases. For example, a monopoly government purchaser could undertake a competitive tender or negotiation process and enter into contracts with a number of providers who would provide specified services for a given period with the services subject to periodic re–tendering. This could be described as "controlled" competition.

The *economies of scope* in emergency ambulance services in the metropolitan areas do not appear to be significant. MAS noted that virtually all of its support services are already contracted out (including call taking and dispatch, fleet management and maintenance, aircraft operation, information technology, equipment maintenance and training), and presumably a new provider could undertake a similar strategy.

Metropolitan ambulance emergency services are clearly not a natural monopoly as there appear to be only modest *economies of scale* in delivering such services in the metropolitan area. These are largely related to rostering, fleet size and corporate overheads and should be broadly comparable to those facing non–emergency providers. Some of these could be at least partly overcome by contracting out some of these services. Some relevant evidence is provided by VPT, which argued that lower costs could be achieved through a doubling of its fleet size to 40 vehicles. Conversely, in the metropolitan area, substantial cost savings have been claimed by MAS through sub–contracting non–emergency stretcher services to a number of private providers with relatively small fleet sizes, suggesting that the scale economies in fleet size, rostering and corporate overheads are not large. Some private providers were of the view that the metropolitan market could initially support at least two or three major emergency ambulance service providers and some believed that up to five or six providers were potentially viable in the longer term. MAS over recent years has had between three to six management units within its emergency operations, which strongly suggests that a similar number of providers would also be potentially viable. It is clear is that more than one provider is potentially viable. Additional analysis would be required in order to develop a firmer idea of an optimal number of providers with the evidence at hand suggesting that it could well be in the range of three to six.

Rural markets provide a different story. *Economies of scale and scope* are significant compared to the small case load, and in some cases appear to be able to support only a single combined emergency/non–emergency provider. Whether this applies to all rural areas is less certain. In some rural areas, separate non–emergency services are clearly viable as they already exist and some private operators claim that they are able to be unbundled in the case of larger regional centres (such as Geelong, Bendigo, Ballarat and the La Trobe Valley).

It is important to note that even if economies of scale or scope in a market will probably only support a single provider, it is still possible to introduce competition by providing for some contestable process to determine who will be the provider for a given period subject to periodic re–tendering.

Competition

At the end of the day, the majority of stakeholders, including the ambulances services, readily recognise that there is significant room for improvement in the current system and that 'controlled' competition is possible. But how can competition lead to better performance? Competition can take place at a number of levels.

There is potential for competition benefits even within a single provider model. For example, a single government emergency provider might divide operations into a number of ring-fenced internal business units and use best practice benchmarks to drive 'competition by comparison' between these units. Similar benefits can also be expected to result from competition between government businesses.

However, in order to realise the maximum gains from competition, it is necessary to create an environment where there is full contestability to provide services.

Adequacy, Costs and Risks of Contractual and Regulatory Mechanisms

While the majority of stakeholders, including the ambulances services, readily recognise that 'controlled' competition is possible, an area of disagreement is whether the necessary regulatory and contractual mechanisms to underpin 'controlled' competition can be developed in a way so that the government is able to set and enforce standards, specify outputs and monitor outcomes with a high degree of assurance on service quality as well as efficiency. There are additional concerns about whether this can be done at a cost that does not outweigh the likely benefits.

International and local experience tends to suggest that contractual and regulatory mechanisms could be developed which are capable of supporting non–government provision of ambulance services. Ambulance services are currently provided under contract by private bodies in a number of jurisdictions around the world, most notably in parts of the US, and by not–for–profit bodies within Australia. Within Melbourne, the Cranbourne service provides a powerful example of the use of contractors, despite its small scale. As already noted, many aspects of the ambulance services are already contracted out, including the complexity of the call taking and dispatch function. Private hospitals have been financed, built and operated by the private sector in Victoria using contractual and regulatory mechanisms. Aspects of controlled competition have been introduced into the broader health sector in Victoria through case–mix funding and the creation of health networks.

A number of stakeholders point out that such contractual and regulatory mechanisms are more costly to develop and operate than the simpler delegation of responsibility for provision to an accountable government body. These additional costs might be borne by the government or providers. On the face of it, this seems likely to be true in relation to a range of costs, including systems costs, legal and financial advice, administrative costs and compliance costs. However, these costs need to be weighed against any benefits that are realistically expected to flow from the changes. MAS, MFESB and other stakeholders emphasised the need for rigorous analysis of the costs and benefits before making any major changes.

Introducing provider competition and establishing the necessary regulatory and purchasing arrangements does involve some political risks along with the potential benefits. However, a

significant amount of learning has taken place over recent years on these issues, and there is now a much better understanding about how such changes can be successfully designed and implemented. A number of private providers and some other stakeholders believe that these risks can be effectively managed. Some other stakeholders remain sceptical. The Inner and Eastern Health Care Network argued for the benefits of a carefully constructed and phased implementation sequence when considering such changes, with a strengthening of the purchasing role prior to consideration of unbundling service provision and with an initial focus on pilot programs in the metropolitan area.

Workplace Change

A number of stakeholders, including MAS and MFESB, cautioned against overly ambitious change programs, especially given the realities of workplace relations in an emergency services environment. Another theme was that it was time for consolidation and certainty to assist ambulance services to build high–performance organisations, rather than pursuing the path of fragmentation.

Interestingly, MAS acknowledged that a Cranbourne–style sub–contracting model may well be viable, but only with the support of existing MAS staff. One of the problems monopolies sometimes face is in dealing with internal monopolies. Competition from a rival service may create a positive internal dynamic in ambulance services, such as the management and workforce performance improvements observed by ASV South Eastern Region as flowing from competition in non–emergency services.

Industrial relations are clearly a major issue in the industry, with around 90 per cent union coverage, and any change program would need to take into account the importance of the workplace environment. However, a number of the potential changes may well appeal to employees in terms of greater support for the development of the ambulance paramedic profession and a greater diversity of employment options. Indeed, submissions from, and discussions with, a range of individual ambulance service employees reveal a fairly wide range of views on the future of the ambulance services not dissimilar to the range of views expressed by stakeholders generally.

Public Confidence

The MAS submission notes: "emergency ambulance response is an essential service and potential users have limited knowledge about appropriate service standards, but a low tolerance for any perceived or real service failure. Irrespective of industry structure and responsibilities for service delivery, the community will hold the Government ultimately accountable for ensuring the provision of appropriate services."

A number of stakeholders have noted that public confidence regarding ambulance services had suffered significant damage in recent years, primarily in relation to controversies surrounding the process for initial Intergraph contracts. However, most stakeholders acknowledged that the situation had now improved. At a broader level, there are strong reservations held in significant parts of the community regarding the likely outcomes of government service improvement initiatives — in particular, the use of market mechanisms and outsourcing for 'core' government services.

Maintaining public confidence in the ambulance service is very important both to ensure community support for government reforms but also to provide reassurance to potential users on the quality and reliability of the service. However, with careful management and phased implementation, it is possible to achieve change without risking a failure of public confidence. Communications and stakeholder relations strategies are an important part of any major change process.

Conclusions

Metropolitan

Emergency ambulance services are potentially contestable and competition may provide a range of benefits in terms of cost and efficiency without necessarily compromising service quality, equity or public confidence objectives. However, there are preconditions that would need to be satisfied before a decision to introduce controlled competition could be made. These relate primarily to the development of standards, performance monitoring and measurement systems, contractual arrangements and a regulatory framework (as

discussed in more detail in later sections of this report).

Adetailed analysis of any proposed changes to the core emergency response would be required before consideration of implementation. However, some elements of the wider emergency response effort are already provided by organisations other than ambulance services, including the Cranbourne branch, MFESB, private ambulance services at major public events, medical retrieval services and MAS non–emergency contractors in certain situations. It seems entirely plausible that one or more private contractors could play a larger role in the emergency response effort by means of independent centrally coordinated dispatch.

There is a clear conflict of interest between MAS's regulatory/purchaser and service provider roles, and the best way to progress the reforms would be to structurally separate the emergency operations component and give the remaining core of MAS (perhaps combined with some other elements from industry or government) a mandate to become the authority which performs the role of specialist regulator/purchaser for the industry — the controller of the system within which others provide the services. After careful analysis, competition should be tested through some carefully selected pilot program. This would provide valuable lessons for a phased implementation of a full scale competitive system.

It is important to note that this analysis is largely consistent with the basic thrust of the MAS submission's analysis of the importance of a single public ambulance authority, except for one point — namely, the need for the structural separation of the emergency operations division. Other structural alternatives are discussed in the following chapter.

Rural

Introducing competition in rural emergency ambulance services is more complex, and less likely to result in clear benefits. In addition, the sector is currently undergoing an amalgamation process. Adding further contestability at this point may result in significant disruption to the service.

The real gains in rural and regional areas in the short to medium term appear to be from capturing the benefits of amalgamation, and from a more serious consideration of synergies and integration with the health sector and other emergency services and through greater engagement with local communities. The best way to pursue these changes is for there to be a clear split between the regulatory/purchasing role and the service provision role.

This is not to say that competition in rural emergency ambulance services may not be a possibility in the future. However, as with MAS, the initial focus should be on the development of standards, performance monitoring and measurement systems, contractual arrangements and a regulatory framework. Contestability opportunities should generally be pursued in rural and regional areas only after lessons have been learned from initiatives in the metropolitan area.

Recommendations

- Controlled competition for metropolitan emergency ambulance services — which may provide a range of benefits in terms of costs and efficiency — should only be introduced after the development of standards, performance monitoring and measurement systems, contractual arrangements and a regulatory framework.
- In the metropolitan area, to avoid a conflict of interest between MAS's regulatory/purchaser and service provider roles, the emergency operations component should be structurally separated from the highest level functions of MAS — general control of the system, setting standards, etc.
- The remaining core of MAS combined with other elements from Rural Ambulance Victoria and possibly the Department should be constituted as an authority to perform the role of specialist regulator/detailed purchaser for the industry.
- Competition should be phased in for the metropolitan area.
- Contestability opportunities should be pursued in rural and regional areas only after lessons have been learned from the initiatives in the metropolitan area.

Chapter 5 discusses alternative structural models within which these basic directions of change could be implemented.

4.4 Urgent

Issues

Urgent cases are those where a patient in an unstable or potentially unstable condition needs to be transported, but where it is not acutely time sensitive. Often urgent cases are transfers between hospitals. For example, a car accident patient requiring specialist neurosurgery is stabilised in a regional hospital and then transferred to a specialist metropolitan hospital. Emergency cases have similar requirements to non–emergency cases in that they require both a transport element and a significant clinical element.

It would be wrong to categorise the urgent market as completely distinct and separate from emergency and non–emergency markets. In reality, there is a wide range of case types which each have distinct clinical and transport requirements. There are significant overlaps or grey areas between the 'markets', and there do not appear to be any agreed industry–wide categorisations.

Notwithstanding this, the market for urgent cases is somewhat different to that for emergency cases in that there are a number of players currently providing the service or elements of the service. These include:

- Ambulance services, using their emergency response resources.
- Medical retrieval services (in conjunction with ambulance services).
- Some private contractors.

While ambulance services do not have a state–wide monopoly on the market for urgent cases, in many cases they are the dominant or only provider for a given area. Medical retrieval services are often focused on some specialist area, such as neonatal or paediatric cases, and usually only provide the clinical element of the service. Private contractors can undertake some urgent cases, as sub–contractors to MAS or under contract with a hospital. Sometimes, it has proved to be uneconomic to provide such services because of the limited case loads, especially in rural areas. Conceivably, the case load for urgent inter–hospital transfers to and from a number of major hospitals may provide a private contractor with an economic scale of activity.

It is fair to say, however, that ambulance services have substantial competitive advantages in this market. As a result of their emergency operations, ambulance services have all the necessary vehicles, equipment and skilled staff covering the State, and substantial spare capacity (especially in rural areas) given the need to resource for the peaks in emergency response. To a certain degree, they also act as a major purchaser and regulator on behalf of Government. There are, however, also a number of constraints on the ambulance services. Prices for ambulance services (with the exception of public hospital business) are set by Government and, in the case of MAS, separate prices are determined for emergency attendance, emergency transport, air transport and non–emergency transport. The categorisation of a case as emergency or non–emergency is largely left to the ambulance services, and there have been disputes between ambulance services and hospitals as to how cases are categorised.

Stakeholder Views

Ambulance Services

Ambulance services were generally of the view that, as long as they conformed with competitive neutrality pricing provisions, they should be free to compete in relation to urgent cases in the market for inter–hospital transfers. Some ambulance services believed that some hospitals expected to pay a 'non–emergency' rate for higher quality services required for urgent cases. Some ambulance services also felt that if hospitals were not willing to enter into contracts for such services, then they should be willing to pay a higher 'stand–by' rate for opportunistic use of ambulance services. Some ambulance services felt at a disadvantage in the urgent market as they could be undercut by private contractors offering lower quality services, and there were incentives in the hospital sector to cut costs, and sometimes little understanding of the appropriate quality of medical transport appropriate for specific cases.

Hospitals

There were concerns from health sector organisations that ambulance services were able to classify cases into higher fee categories, and that this was done in a fairly arbitrary manner. There was also concern that ambulance services had either a complete monopoly or significant market power in relation to certain services. Some were of the view that there should be independent

oversight by the Government of prices and the classification of cases. Others pointed out that ambulance services in some circumstances may well be in breach of the Act (that prices charged are 'reasonable') and possibly of section 46 of the Trades Practices Act (in relation to abuse of market power).

Private Providers

Some providers believed that, in most instances, urgent cases can be undertaken by appropriately staffed and equipped private non–emergency vehicles. However, given the potential need for (and the restrictions on) the use of warning devices, an emergency vehicle is generally chosen. A number of private providers believed that ambulance services should vacate the urgent market, especially for more routine types of cases in the metropolitan area, since private contractors could provide a quality service at a lower cost. Some providers considered that the market for urgent transport of patients is similar to the requirements of the transport of a patient from the scene of a medical emergency, and believed that very few contractors had the necessary skills to operate in this market.

Conclusions

There is a significant grey area between emergency and urgent cases. As noted in Section 4.3, there is scope for private contractors and ambulance services to provide services in this grey area.

Ambulance services should be free to compete for urgent cases in the inter–hospital transfers market (or other urgent or non–emergency markets), so long as they conform with competitive neutrality pricing policies since this should lead to a lower overall cost to the community. Indeed, in many areas, particularly rural areas, ambulance services are the only option, especially in relation to time–sensitive cases with significant clinical needs. In relation to approaches to costing for competitive neutrality pricing, ambulance services should set prices for these services which at least recover the avoidable/incremental cost of the service; and where they have significant market power, they should not be allowed to price above the level of the fully distributed cost of the service (as discussed in Section 3.4).

At the same time, there is no reason why private contractors or other providers should not be able to continue to compete in this market, particularly for specialised services such as medical retrieval. The establishment of more formal licensing/registration arrangements by an independent regulator may be an effective way to assist hospitals and other major purchasers in identifying the basic quality standards applying to private services. Such arrangements should allow the use of lights and sirens under certain circumstances.

Clearly, regard needs to be had to the dependence of rural ambulance services on the non–emergency market. However, if more transparent and output-based funding arrangements are put into place for emergency and if rural ambulance services use the flexibility provided by the competitive neutrality principles and adopt a more commercial approach to relationship building with key regional buyers in their communities, then there appears to be no reason why a rural ambulance service should not be financially viable notwithstanding competition for non-emergency work.

Many of the above comments also apply in relation to the non-emergency market and, similarly, a range of other issues relevant to the urgent market are discussed in the following section in relation to the non–emergency market.

Recommendations

- Ambulance services should be free to compete for urgent cases in the inter–hospital transfers market, so long as they conform to competitive neutrality pricing principles.
- In relation to approaches to costing for competitive neutrality pricing, ambulance services should set prices for these services which at least recover the avoidable/incremental cost of the service and where they have market power.
- Private contractors or other providers should continue to compete in this market. The establishment of more formal licensing/registration arrangements by an independent regulator may be an effective way to assist purchasers in identifying the basic quality standards applying to private services.

4.5 Non–Emergency

Issues

Non–emergency medical transport can be differentiated from emergency/urgent cases by the lower level of clinical expertise that is generally required, and by the fact that cases are generally not time critical. Scheduling can often be done in advance, and multiple patients can often be transported at a single time. The level of capacity utilisation can be much higher than for the emergency response. A range of transport forms are used, including stretcher vehicles, hoist buses and cars.

The major buyers of non–emergency medical transport services are the Victorian Government in relation to Healthcare card holders; the Commonwealth Government in relation to DVA patients; TAC; Workcover; and public hospitals (for inter–hospital transfers). Private insurance does not generally cover non–emergency transport.

In the metropolitan area, the emergency and non–emergency responses are operationally separate functions. The non–emergency stretcher transport function is undertaken by private providers sub–contracted to MAS, and the clinic cars are staffed by MAS employees. In rural areas, the lower level of demand often makes such separation uneconomic, except perhaps in some of the major provincial cities. As a result, in–house emergency crews also undertake non–emergency work in their down–time.

The non–emergency market has always been subject to some degree of competition from in–house medical transport operations run by hospitals, from specially designed taxis, from private vehicles, and from more conventional forms of transport. Focus on this area was heightened in 1993, when emergency departments of public hospitals were given responsibility for the cost of inter–hospital transfers and the ability to engage private contractors.

A key question is whether ambulance services are enjoying unfair competitive advantages (or indeed disadvantages) over private operators in the non–emergency transport market as a consequence of their government ownership, and whether this is justifiable on public interest grounds.

It is Government policy to fund pensioner transport. The Government requires the ambulance services to provide free emergency and non–emergency medical transport for Healthcare card holders, and defined groups (including some categories of mental health patients). In the case of non–emergencies, a doctor's authorisation is required as a check on abuse. The Government does not provide an explicit CSO payment, but rather deficit funds the ambulance services through an annual budget negotiation process, although DHS has indicated its intention to shift to an output based budget. In effect, the Government is acting as an insurer for this class of patient. Similarly, services to DVA patients (who are not also Healthcare card holders) are funded by the Commonwealth Government. Healthcare card transport accounts for a large and rising component of the non–emergency workload of ambulance services, and this arrangement effectively excludes private medical transport operators from access to this work, unless acting as a sub–contractor to an ambulance service.

Given the growth in the use of 'free' non–emergency transport, there is a real question about the effectiveness of relying almost solely on doctors' opinions regarding the need for an ambulance. Because doctors are often sensitive to their patients' financial needs, they often order ambulances (because the patient will incur no charge), even though on clinical grounds, the decision may not be justified. This suggest that there is a need for stricter guidelines, protocols and/or controls on the dispatch of 'free' non–emergency services. There may also be some benefit in users bearing some proportion (probably small) of the cost of the service in certain situations to deter unnecessary usage. However, the danger of introducing a co–payment for ambulance transport in non–emergency cases is that patients may decide against an ambulance on financial grounds when, on clinical grounds, it is necessary — thereby increasing the risks to their health. In other words, the decision to use an ambulance should not depend on a patients' income; rather it should be based on clinical need.

An alternative option would be give doctors a budget for patient transport on the grounds that financial incentives are likely to be more effective a the level where decisions are made — in this case, by the doctors themselves. However, such an approach may suffer from administrative complexity.

The root of this problem is clearly the separation of decision making from financial incentives. However, any solution to the problem would need to affect the structure of health service purchasing decisions more broadly and, as such, is beyond the scope of this review.

Ambulance services also undertake a range of quasi–regulatory activities, such as standards setting and accreditation, which can potentially be in conflict with their business interests in competing for contracts. The issues of standards and licensing, training and accreditation are addressed in subsequent sections of this report.

Level playing field issues are addressed to some extent in that, when bidding for non–emergency contracts, ambulance services are required to apply the Victorian Government's competitive neutrality policy framework. The higher cost structures and the application of the competitive neutrality pricing principles has, in some instances, led to prices far above those of competitors. It is claimed that private contractors can undercut ambulance services by as much as 50 per cent for non–emergency work. Some ambulance services argue that there could be a much more efficient use of resources if they were able to tender at something closer to their true incremental cost or if more rigorous standards were applied by hospitals as part of the tenders. This is a particularly important issue in rural areas, where substantial spare capacity is available from the emergency response resources. Ambulance services have certain advantages over some private providers in that ambulance officers employed by MAS can administer certain drugs under medical supervision (as can, for example, registered nurses). Ambulance officers working for private providers can administer drugs within the scope of practice as defined in non–emergency contracts; however, the scope of practice of such contracts is limited, relative to the emergency sector.

Some private non–emergency providers believe that they should be accredited in the same way as private hospitals are accredited including certain standards and accountabilities. They also believe that there should be provision for the accreditation of courses and occupational registration, which recognises the competencies in the industry and places appropriately qualified ambulance transport officers on a similar footing to registered nurses.

The recent Ministerial Taskforce Review of Non–Emergency Patient Transport Services considered many of the above issues in its August 1998 report. It made a range of recommendations regarding the benefits from the development of state–wide standards and protocols, and the application of quality assurance requirements to non–emergency medical transport. However, the report generally stopped short of recommending that these be implemented through government regulation, in many cases pending the outcome of this review.

Stakeholder Views

MAS

- There is already a significant level of competition in the non–emergency market.
- Private contractors not contracted to MAS are unable to access the Concession Card component of the market. Additional competition could be introduced by more transparent government payments for CSO transports. Funding both MAS and the hospitals on a per transport basis would extend the scope of competition between MAS and hospital contractors. A more radical approach would be to pay service providers directly, but this would significantly complicate regulatory requirements.
- MAS has implemented the principles of competitive neutrality pricing.
- There are strong financial and operational reasons for ensuring that the emergency service provider is not excluded from the non–emergency market. The ability to use emergency and non–emergency resources flexibly for high–end non–emergency patients and low end emergency patients can create significant resource efficiencies.

Rural Ambulance Services

- As mentioned previously, non–emergency work for rural ambulance services is crucial in utilising the significant down–time of emergency ambulances, and results in a lower overall cost to the community. The private sector is not present in many rural areas, and would find it unprofitable to operate in many cases. Some believed that ambulance services can operate at a disadvantage to private contractors given their overriding emergency responsibilities and higher cost structures.
- The South Western region noted that competition from the non–emergency market has been the catalyst for improving efficiency levels, and possibly standard of care. Staff and management have both responded to competition.
- Some services noted that there should be stricter guidelines on the use of ambulance transport for non–clinical reasons.

Private Providers

- Many private providers believed that non–emergency providers should be subject to accreditation and state–wide industry standards described and maintained by a regulatory authority. Some thought that the current standards applied to MAS contractors would provide a good basis for the development of these standards. Other providers did not support regulation other than vehicle licensing and the prevention of a monopoly, such as is currently occurring with the MAS contractors.
- Private providers generally believed that they could provide quality non–emergency services at a significantly lower price than Ambulance Service – Victoria. Most also argued that private providers should have direct access to government–funded pensioner transport work, rather than sub–contracting via an ambulance service.

Health Sector

- Inner and Eastern Health Care Network opposed the introduction of co–payments to control clinically inappropriate use of ambulance services given the evidence that this was likely to reduce the use of ambulance services in circumstances which are clinically warranted. The Network also supported wider access to pensioner subsidies.
- Some hospitals thought that non–emergency vehicles could be fitted with lights and sirens, and, under some circumstances, be able to upgrade to emergency as there were repeated cases of patients deteriorating acutely in transit.
- Hospitals generally agreed that the non–emergency market was competitive, and supported the retention of their ability to competitively tender for medical transport services.

Major Users

- Generally supported the notion of some form of industry standards and accreditation.

Conclusions

The report of the Ministerial Taskforce on the review of non–emergency patient transport services provides a good analysis of a range of issues and will not be repeated here. The consultant generally agrees with the thrust of most of the recommendations in the report of the Ministerial Taskforce, with the exception that it sees significant benefit in incorporating many of these standards into a more formal regulatory framework.

The reasoning is that if an independent regulator/purchaser is proposed for emergency, and if effective competition is to develop, then it is important that a single regulatory framework should apply to both emergency and non–emergency sectors. This framework could incorporate registration/licensing of providers and could recognise the different levels of service in the industry and their associated requirements. Registration would be voluntary, but buyers of services such as the Government, hospitals and sporting bodies would be free to specify certain standards when purchasing services.

This regulation should be 'light–handed' — that is, it should not be overly prescriptive and should rely to the greatest extent possible on reference to industry–developed standards or codes of practice and existing quality assurance processes. In particular, such regulation should not add significant costs to the industry or act as a barrier to entry to the industry for appropriately qualified providers.

Subsidies for pensioner transport should be directly contestable by private providers and ambulance services. Hospital patient transport payment arrangements should be reviewed at the

same time. Improved guidelines should be developed in relation to the authorisation of subsidised pensioner transports to ensure that ambulance transports are not used for non–clinical reasons. The viability of other mechanisms to deter unnecessary usage should also be considered, whilst recognising that the decision to use an ambulance should be based on clinical need, rather than on the patient's income.

Recommendations

- If an independent regulator/purchaser is proposed for emergency responses, and if effective competition is to develop, then a single regulatory framework should apply to both emergency and non–emergency sectors.
- The regulation should be 'light–handed' — ie, it should not be overly prescriptive and should rely to the greatest extent possible on reference to industry–developed standards or codes of practice and existing quality assurance processes.
- Subsidies for pensioner transport should be directly contestable by private providers and ambulance services. Hospital patient transport payment arrangements should be reviewed at the same time. To ensure that ambulance transports are not used for non–clinical reasons, improved guidelines should be developed in relation to the authorisation of subsidised pensioner transports.
- Consideration should also be given to the viability of other mechanisms to deter unnecessary usage.

4.6 Pre–Hospital Care

Issues

As described above, the clinical function of the emergency response is concerned with pre–hospital care. While this is integral to the emergency response, it is discussed separately here to highlight that it is an activity that in certain circumstances can be supplied separately by a range of potential providers.

This function is already contestable to some degree and, depending upon the situation, ambulance paramedics share this role with, for example, doctors and nurses staffing medical retrieval services, GPs treating emergencies in their surgeries, industrial doctors, nurses, paramedics or first aid providers in the workplace, and first aid providers at major public events. The possibility of unbundling this element of the emergency response has already been discussed in relation to the First Responder program and the option of paramedic flying squads in cars. The trend for the use of ambulances as effectively a 24 hour 'free' locum medical service provides another example of ambulance officers providing medical services in the community (although the appropriateness of this service needs to be analysed, given that it is not a core function).

Similar issues apply to urgent cases where patient carers require the appropriate level of clinical training and experience. For non–emergency cases, there may be requirements for first aid training of staff, but not for more advanced pre–hospital care capabilities. The emergency communications capability of ambulance services could also potentially provide a platform for telephone medical advice. Ambulance officers operating in broader medical roles can be particularly important in rural communities, especially smaller communities.

Stakeholder Views

- Most stakeholders believed that there were significant benefits available from closer integration with the health sector, particularly in many rural areas.
- Some ambulance services expressed interest in undertaking additional health related services complementary to their skills and resources bases.
- Some stakeholders believed that use of emergency ambulances as a 24 hour locum service was likely to be an inefficient use of resources.

Conclusions

The clinical capabilities and resources of ambulance service can clearly be used within the broader health sector especially in rural areas.

The structural separation of corporatised ambulance operations from the regulatory/purchasing role, as discussed earlier, provides a structure that allows the organisation to focus on its core competencies and pursue additional activities that are complementary to its skills and resources.

If ambulances are to be used to deliver mobile out–of–hours medical services, then they should be funded to do so — otherwise, alternatives such as transport to local 24 hour clinics or a telephone medical advisory service should be considered. (In this context, it is noted that the Discussion Paper of the ongoing Health Services Policy Review is recommending a 24 hour telephone medial advisory service.)

Recommendations

- If ambulances are to be used to deliver mobile out–of–hours medical services, then they should be funded to do so.

4.7 Training

Issues

Training of ambulance officers has traditionally been undertaken by the Ambulance Officers Training Centre (AOTC). In 1996, a Ministerial Taskforce addressed issues relating to education and training in the ambulance service. The Taskforce took the view that, while it was not appropriate for AOTC to continue its monopoly position, overall training requirements were insufficient to justify more than one State–funded provider. Recently, ambulance officer training has been mainstreamed, and Monash University has been initially contracted to provide that training. Related courses are now also being offered by Victoria University of Technology.

There are, however, aspects of the current arrangements that may raise competition policy issues. One issue is whether alternative training providers may compete in offering courses leading to qualifications recognised in the industry. Another issue is whether the ambulance services have potentially restrictive control over the avenues for trainees to gain the on–the–job experience necessary for the attainment of higher level qualifications.

Stakeholder Views

Ambulance Services

- MAS fully supported the current movement towards a pre–employment model for paramedic training, seeing no need to retain legislative provisions for ambulance training. Provision of paramedic education and training is contestable, having recently been subject to competitive tender. There will be an optimal number of student places for adequate clinical supervision during training. Larger number of students would stretch the limited capacity of ambulance services to provide supervised on–road experience, resulting in skill loss of graduates. Supervised clinical experience should be provided to all students in government funded places or those employed by ambulance providers. Coordination of students from approved educational and operational providers is a complex administrative task which MAS can appropriately manage.
- A number of rural ambulance services noted that more than one provider may not be optimal given the relatively small numbers to be trained each year (around 80–100 recruits per annum state–wide), and that clinical placements should be negotiated between the training provider and ambulance services. A number expressed interest in industry training provider accreditation and occupational registration.

Other Providers of Patient Transport

- In general, there were strong views that, in the past, the ambulance services and AOTC have effectively provided a barrier to many private providers or their employees seeking certain ambulance training. There was mixed support for the current arrangements, with uncertainty regarding access to training services at Monash and disappointment at limiting the arrangements to a single provider. Some providers believed there should be greater access to training. It was thought that a number of private providers and educations institutions could provide good training and relevant experience. There was general support for a move to a system of training accreditation and occupational registration along similar lines to other medical professions, such as for other health professions.
- St. John Ambulance argued that recent changes have gone some way towards mainstreaming of training; however, the Monash contract does reflect the exercise of monopoly purchasing power. Given the ability of an industry reference group to develop

competencies and educational requirements for various grades of people employed in the ambulance industry, St. John Ambulance saw no reason for the current restrictive contracting arrangements, except as interim arrangements. In its view, the question of clinical placements should be resolved between educational institutions and providers — however, contractual arrangements could facilitate this.

Training Providers

- AOTC — The future provision of ambulance paramedic education has been the subject of a contestable process. AOTC would be concerned if there was no control by the industry on the supply side of education and training. At present, all student places for ambulance paramedic education — be they VET or higher education sector — are publicly funded. Education providers who enrolled students in excess of industry's needs may exceed the limited capacity of ambulance service to provide adequately supervised on–road clinical experience for no ultimate gain. The AOTC believed the transfer of ambulance officer training to the university sector requires a medium to long term view (of around six years). Unnecessary competition could reduce the critical mass of students and potentially impede desired outcomes. Market forces should not be the determinant of available student places, and the more appropriate model is that of a monitored balance of supply and demand with an emphasis on the demand side, with student numbers being determined by the available clinical training (not classroom) resources. The AOTC was very supportive of the recent decision by the Convention of Ambulance Authorities to investigate a proposal to implement an Australian Ambulance Education Council (AAEC). There should not be legislated regulation of educational programs, but DHS should contribute to the development of AACE to achieve the required objective of external accreditation. Supervised clinical experience should be provided to all registered students in government funded places, or those already employed by ambulance providers both emergency and non–emergency. The AOTC would be reluctant to see the evolution of training programs which did not involve supervised clinical experience integrated with off–the–job training components.
- Monash University — The transfer of ambulance officer education to the university sector requires a medium to long term view to be taken by government of its investment. For a three year undergraduate program, as planned for ambulance officer education, it would be reasonable to adopt a ten year time–frame. It would be prudent to allow the current arrangements to mature before introducing new players to the field. The more appropriate model (than market forces) for ambulance education is a monitored balance of supply and demand with an emphasis on the demand side, set in the context of available clinical training resources. Clinical placements should be available to all Monash ambulance officer students and could be arranged on a contractual basis between the University, the purchaser and the provider(s) of ambulance services. There are advantages to locating ambulance officer training with a Faculty of Medicine, and there are opportunities for the development of an emerging profession — for example, learning informed by research, development of clinical problem solving and decision making skills, collaborative workforce at the interfaces with other emergency and health care providers, and ultimately self regulation. There should be an external accreditation process for the ambulance education program coordinated by Monash, and Monash supports the recent decision of the Convention of Ambulance Authorities to investigate the implementation of an AAEC to provide this function. In the interim, the proposed industry–based board of studies in MUCAPS could adequately perform this role in Victoria.
- Victoria University of Technology (VUT) — noted that currently only (Monash) courses are 'accredited' by ASV. The VUT course is, however, accredited by OTFE. The VUT believed there is scope for more than one provider in the State. VUT are introducing a three year degree course and hope to negotiate some clinical placement arrangements with ASV. The ideal outcome is for an Industry Registration Board, and it envisages an independent accreditation process at three levels: (i) institutional accreditation; (ii) individual/occupational, and (iii) registration provider accreditation. There is currently no interstate transferability of qualifications, and arrangements vary markedly in each State. Ideally, registration of providers and individuals would be at a national level to facilitate transferability of qualifications between States. Clinical placements could be provided and funded by agreement/negotiation with service providers. There is a strong desire for para–medicine to move forward as a profession with the large and growing demand for paramedics outside ambulance services, and the opportunity for expanded scope of practice to meet demand for services in rural areas.

Other Stakeholders

- The Victorian Community Advisory Group on Mental Health raised the issue of the need for improved training for ambulance officers on mental health issues.
- Individuals, primarily ambulance services employees, raised a number of training issues including the need for an industry–wide classification structure, qualifications recognition and professional registration.

Conclusions

There is general support amongst stakeholders for the development of some form of industry–wide training accreditation framework. There appears to be no reason why training in the occupations required to deliver ambulance services cannot be managed under the broad framework that nowadays applies to training in broadly comparable areas, with the industry — and the regulatory authority for ambulance services — having a key role in setting industry standards for competency–based training. Ideally, such arrangements would be pursued at the national level and for all major sections of the industry to have representation to allow for some local variation. The Government could legitimately pursue a facilitative role in relation to such training issues.

Access to clinical placements (indeed, to qualified staff) would be an important factor if the Government wished to introduce competition in the form of one or more private providers. This would be an important transitional issue, both in terms of the transition to pre–employment training, but also in terms of the possible transition to multiple emergency ambulance service providers. The Government would need to construct the future purchasing framework in such a way that necessary clinical experience is accessible to employees of all service providers, with the costs of those providing the experience opportunities taken into account in that purchasing framework. For example, a requirement could be included in the contract or service agreement with the incumbent ambulance service providers for a certain number of clinical placements for students on a pre–employment basis.

Beyond the powers necessary for the purchasing and standard setting framework, there does not appear to be a specific need for legislative support in the Ambulance Services Act in relation to training issues.

Recommendations

- Training in the occupations required to deliver ambulance services should be managed under the same general framework as applies to broadly comparable areas, with the industry — and the regulatory authority for ambulance services — having a key role in setting standards. Ideally, such arrangements should be pursued at a national level and for all major sections of the industry having representation.
- The Government would need to construct the future purchasing framework in such a way that necessary clinical experience is accessible to employees of all service providers, with the costs of those providing the experience opportunities taken into account in that purchasing framework.

4.8 Subscriptions and Insurance

Issues

Subscriptions are essentially insurance products. Subscriptions are effectively in competition with other forms of health insurance. There are numerous insurance providers and the market for insurance products is quite competitive. Ambulance services are not subject to the same regulatory requirements as other health insurance providers. In addition to their insurance element, there is a "donation" aspect to ambulance subscriptions, reflecting their image as community–based, not–for–profit organisations. (It is interesting to note, for example, that many pensioners take out subscriptions even though they are entitled to free ambulance services.)

The level of the subscription fees is not actuarially determined, and results in a significant net income flow to the ambulance services. This results in a fee that is higher than it needs to be, which may deter more price–sensitive potential subscribers, and leads to equity and access concerns. Under the current arrangements, this income flow has effectively been used to cross–subsidise some of the 'free' services provided to Healthcare card holders.

The main issue for competition is whether the tying of subscriptions to some providers of ambulance services would confer a significant advantage on that provider in a competitive environment.

Subscriptions are clearly an important source of net income to ambulance services and reduce the burden on Government funding. They rely to some extent on reciprocity between ambulance services with distinct areas both within Victoria and, in some cases, interstate. The existence of an established base of subscribers could potentially provide a significant competitive advantage to an ambulance service — assuming subscribers were tied to it — in bidding against a new provider.

Also, how can a subscription service be operated in the case where ambulance services are not delivered on a geographic basis but are unbundled? One option is to separate the subscriptions scheme from the particular ambulance service. In competition models where the purchaser was a statutory authority, then this body might be well placed to undertake this role. However, if the direct nexus with the ambulance service were broken, would this impair the attractiveness of the scheme? Certainly, those that view their subscription as a donation to a specific provider may be less keen to subscribe in an environment of multiple providers. Other possible approaches are to allow new entrants some form of access to the subscriptions system and/or to regulate subscription prices to actuarially warranted levels. Conceivably, the attractiveness of the subscriptions product to low risk groups could be enhanced by the latter, and to all groups if the subscription covered services from any provider (at least in emergency situations).

Stakeholder Views

Ambulance Services

- MAS noted that the Membership Subscription Scheme is a critical source of revenue for MAS and the rural services ($39.5 million in 1997/98). Under the current Act, there are essentially multiple schemes and MAS is of the view that there should be a single scheme owned by the services. The scheme operates in a market that is highly competitive. Tax exemptions available to MAS can also be accessed by the private health insurance funds. The ambulance scheme should benefit from government policies such as the 30 per cent rebate for members, given that this benefit is available to its competitors. There is potential to increase memberships, but this will be dependent on maintaining close links with ambulance services.
- North Western Region noted that subscriptions were an important source of funds, but that maintaining the subscription scheme in its present form would be anti–competitive. It seems possible that the subscription scheme could continue to operate under a competitive model. It would be possible to create a state–wide generic scheme operating across private and public ambulance services. However, there were some doubts about the sustainability of the scheme given the trend in health insurance. If a single regulator/purchaser was established, then the scheme should continue and should be administered by this body.
- South Eastern Region commented that subscriptions could be collected by the regulator/purchaser to subsidise the funding of ambulance service provision. Also, the feasibility and desirability of a small compulsory state levy could be explored.

Private Providers

- VPT was of the view that under a competitive system where the future model contains a statutory authority with regulatory and purchasing roles, the statutory authority would also manage the subscription scheme. This would have the advantage of maintaining an important source of revenue. It is important that the scheme is maintained and managed by the statutory authority in order to preserve public confidence.
- A number of other providers were of the view that the current subscriptions scheme had the potential to provide an unfair competitive advantage and favoured a scheme operated by a regulator/purchaser. Some supported the idea of a compulsory levy.

Health Sector

- Mt Alexander Hospital suggested that a link be established between accredited services and subscriptions.
- Wodonga Regional Health Service suggested that subscriptions should cover a patient for inter–hospital transport, as ambulance charges borne by rural hospitals are excessive relative to the funding provided by case–mix.

Conclusions

In a competitive environment, the combination of non–actuarially determined subscription rates and a seemingly strong "brand" may provide a significant competitive advantage to the incumbent ambulance services. This brand appears partly to be the result of the image of the ambulance services as community–based, not–for–profit organisations, noting that a significant number of pensioners maintain a subscription even though they are entitled to free services.

Whether a subscription scheme is sustainable in the longer term in a competitive environment, or in the case of being separated from the ambulance services, is questionable. However, there are doubts about whether the current subscription scheme is sustainable in the longer term in any case, given the trends in health insurance.

It would certainly be advantageous for Government to be able to maintain this source of net revenue to the industry for as long as possible. In the case of a move to a competitive environment, the option of a single state–wide subscription covering public and private providers appears to be viable, at least in the medium term, if marketed correctly. The scheme could be overseen by Government or the regulator/purchaser, with the operation of such a scheme outsourced to the private sector (as MAS already does). Provisions regarding the subscription scheme could be made a condition of the contracts/service agreement with service providers.

It seems unlikely that the Commonwealth Government would be interested in extending the 30 per cent rebate to ambulance subscriptions, although buyers of private health insurance schemes that include ambulance coverage will qualify for the rebate.

Recommendations

- In the case of a move to a competitive environment, consideration should be given to the option of a single state–wide subscription covering public and private providers, at least in the medium term.
- The scheme could be overseen by the Government or the regulator/purchaser, with its operation outsourced to the private sector.
- Provisions regarding the subscription scheme could be made a condition of the contracts/service agreement with service providers.

4.9 First Aid Education

Issues

Ambulance services also undertake activities to raise public awareness of emergency and first aid issues. Public education is seen as an important complement to its emergency response work.

Ambulance services provide first aid courses to complement their emergency activities and to usefully utilise the down–time of emergency staff. This is a minor component of ambulance services' activities. A wide range of organisations provide first aid courses, including St. John Ambulance, TAFE Institutes and some private providers.

Stakeholder Views

- St. John Ambulance described the market for first aid education services as highly competitive with a wide spread of providers and saw no need for the involvement of ambulance services.
- ASV South Eastern Region noted that this area was currently open to competition and that any emergency services ambulance provider would have a marketing advantage in this area. It was of the view that the issue of whether industry first aid requirements should be deregulated is outside of the scope of the review of the Act.

Conclusions

The market for first aid education is clearly competitive. Ambulance services should not be precluded from providing services in this market on a commercial basis, so long as they conform with competitive neutrality pricing policies.

Under a competitive model, it may well be that certain types of first aid education are seen as an important component of the bundle of services that the Government (or an ambulance or other health purchasing body) would wish to subsidise in pursuing broader health outcomes. The purchaser would be free to use competitive mechanisms to source the desired services, and ambulance services would not be excluded from consideration.

Recommendations

- Ambulance services should not be precluded from providing services in the market for first aid education on a commercial basis, so long as they conform to competitive neutrality pricing principles.

4.10 Emergency Management

Issues

Emergency management involves the plans, structures and arrangements that are established to bring together Government, voluntary and private agencies in a comprehensive and coordinated way to deal with the whole spectrum of emergency needs, including prevention, response and recovery.

A state emergency response plan (originally known as DISPLAN) exists for the coordinated response to emergencies by all relevant agencies. The emergency service organisations (along with other community organisations) play an integral role in emergency planning, which is designed to ensure that the activities of the various emergency organisations (both voluntary and permanently–staffed), are coordinated to avoid conflict, wastage and oversights.

The main concern for this review is whether emergency management objectives can effectively be met under a competitive model for emergency ambulance services.

Stakeholder Views

- The Department of Justice noted that ambulance services are integral components of Victoria's emergency management resources and arrangements, and that it is vital that ambulances services continue to participate in emergency management planning, training, exercising and operations as full participants, whilst continuing to absorb the costs consistent with their public safety charter. Adequate emergency ambulance resourcing is needed in a strategic spread throughout Melbourne and the rest of the State to respond to major emergencies within reasonable response times. The higher the number of organisations involved in emergency management, the greater the complexity of achieving well coordinated operations, planning, exercising, etc. In this respect, the amalgamation of the rural ambulance services should improve the level of coordination with other agencies.
- MAS argued that any changes to industry structure must ensure that the capacity for ambulance response to a major emergency is maintained. Accountability and public confidence are issues of particular significance when dealing with a disaster. A single emergency ambulance service is clearly in the best position to ensure the necessary coordination of ambulance resources. Any disaggregation of service provision will tend to diffuse responsibilities and increase the complexity of resource coordination and the risks of failure to provide an adequate response.
- St. John Ambulance noted that Victoria has in place, under the Emergency Management Act, well developed and well supported coordination systems for the management of major emergencies, and that these allow for the deployment of resources regardless of the agency which owns or controls them. Arrangements already exist with government agencies (eg, Vic Roads, many municipalities) for contractors to respond to emergency situations. Discussions in the State Emergency Response Committee to resolve broader issues of risk sharing when contractors are asked to carry out tasks beyond the narrow confines of their contracts are sufficiently advanced as not to be a barrier to change within ambulance services. The re–assignment of Medical Displan to a more neutral reporting relationship with DHS is a relatively minor task. Unbundling some of the elements of treatment and transport capacity for major emergencies from the routine operations of ambulance services could bring benefits in the streamlining of operations and the clearer identification of the costs associated with preparing for major emergencies — for example, allowing non–government agencies such as St. John Ambulance to restore rapid response support facilities (noting that St John Ambulance maintained a rapid response capacity in the past, demonstrated at events such as at the Westgate Bridge collapse and the Violet Town train crash).
- A number of private providers believed that emergency management requirements were capable of being incorporated in contracts and/or licensing arrangements for private emergency ambulance providers. Some noted that MAS already had contracts with private contractors that included provisions for their deployment in the case of significant emergencies.

Conclusions

Under a competitive model, care would need to be taken to ensure that emergency management requirements are not compromised. While multiple providers may increase the complexity of emergency management to some extent, contractual and licensing mechanisms would appear to be capable of providing for the necessary emergency management requirements. A specialist regulator/purchaser would be in a good position to make objective judgement about the best mix of ambulance resources to provide for major emergencies.

Recommendations

- Under a competitive model, contractual and licensing mechanisms should be used to ensure that emergency management requirements are not compromised.

4.11 Regulation and Purchasing Roles

The sections so far in this Chapter have described the various markets for ambulance services. However, as has become clear in the preceding analysis, there is another important element of the industry and that is the regulatory and purchasing framework.

The existing regulatory and purchasing framework, provided for under the Ambulance Services Act 1986, is in fact the subject of this review and was briefly described in Section 2.4 of this report. Chapter 6 analyses what industry and regulatory structures are required to support a competitive environment for ambulance services into the future. Chapter 5 outlines the proposed elements of the future regulatory and purchasing framework and assesses the adequacy of the existing legislation.

5. ALTERNATIVE INDUSTRY STRUCTURES

Key Points

- **This chapter** examines a range of structural alternatives for the ambulance services industry in the context of the findings from Chapter 4 and against a number of public interest criteria: service quality, access and equity, efficiency, impact on the Budget and ease of implementation. The focus is on emergency ambulance services since there is already substantial competition in relation to most of the other services.
- **Six alternative structures** are identified, although they are not mutually exclusive and mixed models are possible. A description and summary of the findings for each Model is provided below. (The current structure of RAV is most similar to Model 1 and MAS is probably best seen as a mixture of Models 2 and 6.)

1. Single Statutory Authority accountable to Minister/Department — Operating under a specific legislative charter, a statutory authority balances a range of regulatory, purchaser and provider (business) objectives. The Authority is accountable to the Minister and the Department, whose roles include policy, high level regulation and high level purchasing.

- This traditional model of a government monopoly unnecessarily restricts competition and also raises performance and competitive neutrality concerns given the combined role of purchaser/regulator as well as provider — not recommended.

2. Statutory Authority with Ring–Fenced Business Unit accountable to Minister/Department — Similar to Model 1, except that the provider 'business' function is ring–fenced in a separate internal business unit, with a degree of management autonomy and with clear accounting separation.

- Suits the case where there are demonstrable advantages in having a regulatory function co–exist with a service provider function. However, this does not apply for ambulance services — not recommended. This model may nonetheless provide a useful transitional structure if on the way to one of the Models below.

3. Purchaser and Provider — a clear separation of the purchaser and regulator (these roles residing with the Minister and the Department) from a single service provider (a GBE or conceivably a non–government organisation). Appropriate advisory structures would provide for industry input.

- Improves on options 1 and 2 by providing a clear separation of the regulator/purchaser and provider roles, thereby promoting efficiency and providing a basis for competitive neutrality. However, this model lacks a specialist regulator and detailed purchaser at arm's length from government and also unnecessarily restricts competition by having a single dominant provider provider (with any competitors confined to niches)— not recommended.

4. Detailed Purchaser and Provider — This is similar to Model 3 in that there is a single major provider at the operational level. However, it introduces an additional layer of detailed purchaser and specialist regulator (setting standards, etc). These roles would be carried out by an independent statutory authority. The roles of Minister and Department are again restricted to policy, the high level regulatory framework and high level purchasing.

- An improvement on option 3 from the addition of an independent specialist regulator and detailed purchaser. It may be suited to those rural areas that can only support a single provider but in other areas, in particular the metropolitan area, competition may be unnecessarily restricted by limitation to a major single provider (with any competitors confined to niches). At present, a single rural ambulance service is, in fact, a good interim option — to allow the gains from the rural amalgamation process (greater consistency of

practice, etc) to be consolidated before consideration of future options. A single metropolitan provider, perhaps with a number of relatively autonomous internal business units which could be independently benchmarked, could be an interim option for the metropolitan area. This model would the case where a gradualist approach is preferred in moving to allowing a number of providers to share the delivery of the service. This would still be under a single authority, a single integrated area–wide call taking and dispatch system and a uniform system of service standards and quality assurance.

5. **Multiple Geographic Franchises** — A variant of Model 4 with multiple providers each of which is solely responsible for providing services in a specific geographic area.
   - Strict boundaries, especially where they do not correspond to major 'natural' boundaries, are highly inefficient and can endanger patient outcomes — not recommended. However, if the boundaries are 'porous' (ie, the unit best able to respond is always tasked regardless of boundaries) then Model 5 becomes similar to Model 6 below.
6. **Unbundled Contracts** — Essentially a more sophisticated variant of Model 4. Maintains a single, publicly–accountable, specialist government authority to purchase ambulance services in detail on behalf of the community — as the Health Care Networks do — and to set and enforce standards. This single authority could contract more than one major service provider (and possibly 3–6 providers of efficient operational scale in the metropolitan area, conceivably together with some niche operators). Under the terms of their contracts, service providers would generally operate from a loosely defined geographic base but could be tasked anywhere in line with system needs. In this way multiple providers would work as a seamless whole under the umbrella of centralised dispatch and a common system of standards and protocols and quality assurance. Patients and the public would not notice any material change to the quality of the service on the ground. A single emergency 000 number would remain, providers would use similar vehicles, equipment and livery, officers would have the same training and be subject to the same basic set of operating protocols and standards, and pensioner concessions and subscriptions would continue. A single authority would control the system.
   - This model provides for 'controlled competition' by allowing for the maximum expression of competition and efficiency within a tightly coordinated system, subject to effective regulation and sophisticated purchasing which ensures that service quality and equity concerns are properly addressed. Under this model, efficiency would be likely to improve and service quality would be at least maintained at the current level and would in time become significantly better. The model is, however, more difficult to implement than the other alternatives, and would require a phased approach utilising transitional structures and pilots. There would also be a differentiated approach between rural and metropolitan areas.

- **Overall conclusions on structure** — The Allen Consulting Group recommends that a future industry structure should, as a minimum, go to Model 4. However, the policy should allow for a possible transition to Model 6 if detailed business assessments demonstrate that a number of operational units of efficient scale would be capable of operating as independent provider businesses within the single system, with a high degree of assurance that service standards and quality would remain uniformly high or improve. The detail on the exact structure and timing of such a transition would be determined only after careful assessment in the earlier phases of the reforms. Model 2 would provide a useful structure within which potential new structures could be tested and developed prior to new legislation being enacted.
- **The transition** — complex industry structures cannot be implemented overnight. In practice, it is likely that any changes will need to be phased in over a transitional period of a number of years to enable the necessary work to be done to ensure continuity of service and the maintenance of public confidence. The transition also needs to be carefully integrated with the pre–existing initiatives currently being undertaken by the DHS Ambulance Services Branch including the rural amalgamation process, the development of a state–wide ambulance services clinical database, the implementation of the MAS Emergency Operations Plan, the funding and pricing review, the implementation of the recommendations of the Non Emergency Patient Transport Taskforce and the review of the First Responder pilot program.

- **Synergies and integration** — in parallel with the broad structural alternatives, there are clear opportunities for closer integration with other emergency services and the health sector. This could take a range of forms, including cooperation, co–location or complete integration. Such resource sharing possibilities are particularly important in rural areas.
- **Community engagement** — there are many examples of existing community activities that support ambulance services, including volunteer officers or drivers, local auxiliaries and fund–raising activities. In planning for and undertaking the implementation of any different structural models for the provision of ambulance services, it is important that a strong emphasis is placed on maintaining community engagement, especially in rural areas. Relevant initiatives helping to do this include the CERT (Community Emergency Response Team) program and the Key to Survival public health initiative, among others.

5.1 Introduction

This review is forward looking. Its aim is not simply to assess potential restrictions on competition in the current Act, but also to examine at a broad level the issues that will need to be dealt with in the future. An important aspect of the review is to recommend changes that will enhance the quality, responsiveness and efficiency of ambulance services. As a first step, it is useful to consider some broad structural alternatives for the future of ambulance services in Victoria that are consistent with competition policy principles. This section examines some of the possible alternatives.

It must be borne in mind that, in conducting this review, a broad assessment of the public costs and benefits would apply in determining any future legislation, and the principles of efficiency, equity and access would need to be considered. This issue is expanded upon in the following chapter on the regulatory and purchasing framework.

Whatever alternative is chosen, its form is likely to be influenced by the key concepts in government service delivery outlined in Chapter 3 — including the purchaser provider model, contestability and competitive neutrality — and the application of these concepts to the various components of ambulance services described in Chapter 4.

For the purposes of this review, a generic set of criteria suitable for the evaluation of government programs has been used, and these are explained in Box 5.1.

Box 5.1: Criteria used to Assess Options for Ambulances Services Competition

The alternative industry structure models can be judged against the following criteria, bearing in mind that trade–offs are likely to be needed between these objectives.

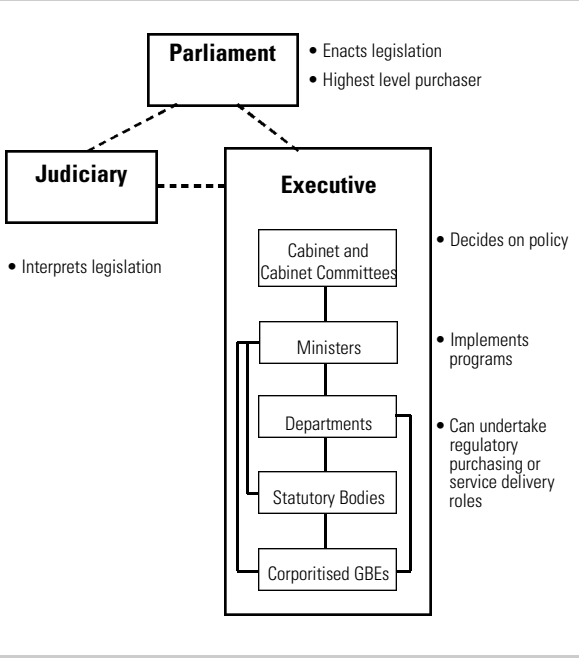
- **Service Quality** — a responsive, reliable and clinically appropriate service.
- **Access and Equity** — accessible to as many people in the community as possible; access to services not being dependent on income/wealth; the degree to which service provision is matched to need; the equitable treatment of different groups and regions.
- **Efficiency** — which can be divided into:
  - **Technical efficiency** (eg, efficiency of service delivery);
  - **Allocative efficiency** (eg, cost–reflective pricing); and
  - **Dynamic efficiency** (eg, incentives for innovation).
- **Impact on the Budget** — the degree to which the model is likely to result in a positive impact on government finances.
- **Ease of Implementation** — the need for major work before implementation.

5.2 Alternative Structural Models

Before presenting the range of alternative structural models, it is important to note that the idea of government as presented in these models is highly simplified. Government is not a single entity but a system of various roles, structures, bodies, powers and accountabilities and an overview of the main elements is presented in Box 5.2. In particular, within government itself there are potentially at least four separate 'purchasing' levels (e.g. Parliament, Minister, Department, Statutory Authority). For the purposes of the discussion of the alternative models below focus on three government levels — the Minister and the Department; a specialist statutory authority; and one or more corporatised Government Business Enterprises (GBEs) — as well as possible non–government provider enterprises.

Box 5.2: Structures and Roles within 'Government'

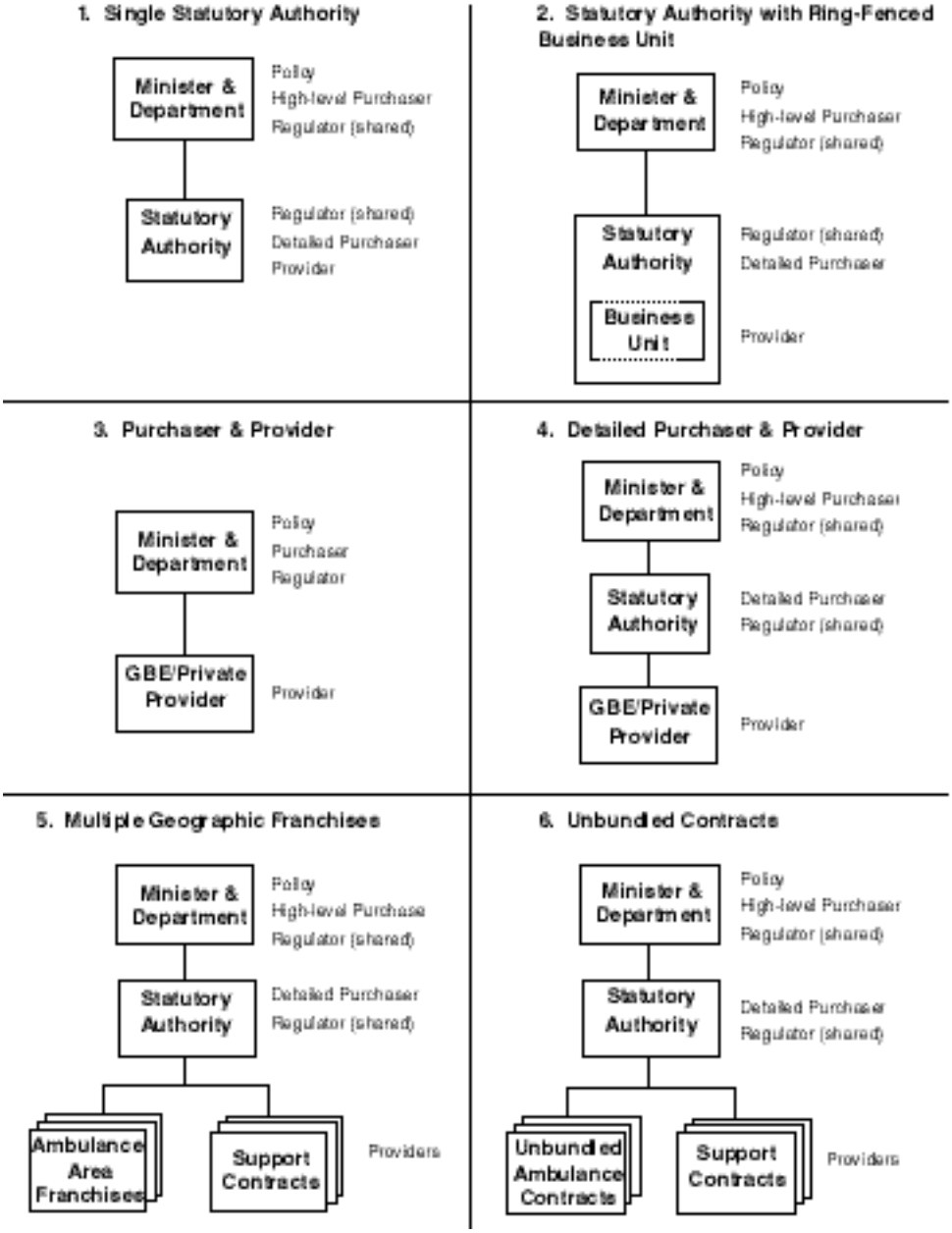
Parliament has a very high level purchasing role in appropriating a supply of money to the executive arm through the budget legislation. High level policy and priorities are decided in the executive at Cabinet level and in the Cabinet committees. Ministers decide on other policies and priorities within their portfolios and, in effect, purchase services as agents of the Parliament from and/or through their departments. Ministers may also act through legislation in some high–level regulatory capacity. Departments support the Minister and often have policy advice, regulatory, purchasing or service delivery roles. Statutory bodies may also exist with specific structures, roles, powers and accountabilities, including potentially a detailed purchasing role. Statutory authorities are generally created under specific Acts and are accountable to Ministers and/or senior departmental officials. 'Corporatised' GBEs are more commercial in nature and structure and may be a corporations law style company. (In practice, however, some corporatised GBEs may more closely resemble statutory bodies). Boards of GBEs are generally accountable to 'shareholding' Ministers with their performance monitored by departments and/or statutory bodies.



Recent Government decisions have in some respects narrowed the range of possibilities. In particular, the Government has decided to amalgamate the five rural ambulance services into the single state–wide Rural Ambulance Victoria, although this leaves open the question of opportunities for competition within that framework. The discussion below briefly examines a range of models that could potentially be applied in either the metropolitan or the rural cases. These are summarised in graphical form in Figure 5.1.

Back to Executive Summary

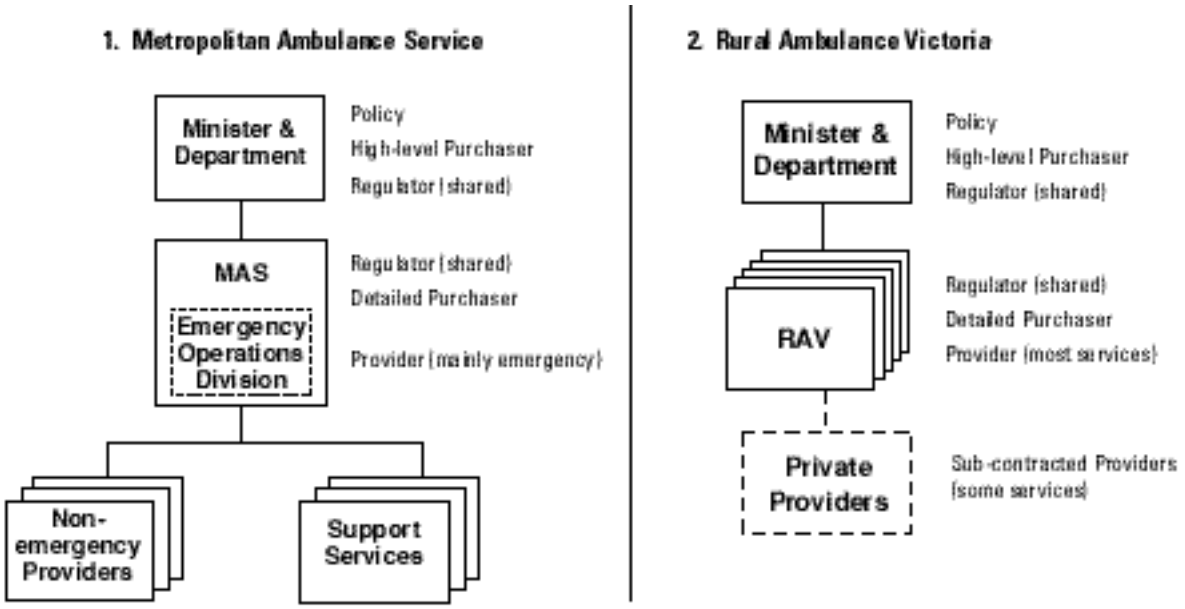
Figure 5.1 Alternative Structures



A number of important points need to be made about these models. The alternatives are not necessarily mutually exclusive and mixed models are quite possible. The structures are mainly concerned with what legislative, administrative and commercial structures the Government would need to provide for under the different models. All the models assume the continuing contestability of non–emergency transport, and the potential ability for providers to sub–contract support services or parts of ambulance services.

For purposes of comparison, it is useful to examine the current industry structure in terms of the above alternatives. None of the six alternatives presented exactly reflects the industry's current configuration. At a broad level, the current structure of Rural Ambulance Victoria is most similar to alternative 1. In contrast, Metropolitan Ambulance Service is probably best seen as a mix of alternatives 2 and 6, although the extent of ring fencing is fairly rudimentary (see Figure 5.2). Both MAS and RAV sub–contract some non–emergency services. However, the extent of such outsourcing is much greater in MAS, which also outsources a wide range of support services.

Figure 5.2 Current Structures



Single Statutory Authority (Model 1)

Description

This has been the traditional model for the provision of ambulance services in Victoria. Operating under a specific legislative charter, a statutory authority has a strong focus on its area of responsibility. In pursuing its charter, it needs to balance a range of regulatory, purchaser and business objectives. It is accountable to the Minister and the Department. If such a model is adopted, it would be desirable for the agency's charter to be clearly spelled out. There are, however, issues about the degree to which a charter should be spelled out in the Act itself; too narrowly defined a charter can unnecessarily limit flexibility.

Issues

This kind of model does not generally provide a good structure for efficiency as incentives can often be clouded through vague or conflicting objectives, political interference, limited managerial autonomy, public sector employment constraints, or access to capital. To some degree, the level of efficiency achieved very much depends on managerial capabilities and workplace culture. This model would, however, provide some efficiency benefits in relation to the establishment of a single state–wide rural ambulance service as a result of the rural amalgamation process.

This model raises a number of competitive neutrality issues since a significant sized provider 'business' is embedded in a body with policy and regulatory roles. This would be of major concern where the provider 'business' was competing with private firms that were also subject to its regulation. There may also be a lack of transparency in determining the costs attributable to the provider, which is critical information for pricing under the competitive neutrality principles. This structure could be attractive in the situation where increased contestability is not thought to provide significant net public benefits.

While an authority may have a mandate for service quality, the ability of the organisation to be responsive and to provide a quality service will be limited by many of the factors discussed in relation to efficiency above. This kind of model may provide a greater focus on access and equity issues, as judgement on key trade–offs between objectives may be delegated to the authority. However, there may also be the scope for the authority to trade these goals off against other organisational goals, such as commercial ambitions or managerial and employee interests.

Stakeholder Views

- MAS argued against this model on the grounds of the need for clear lines of responsibility for policy, regulation and service delivery.
- Most rural ambulance services favoured the continuation of government monopoly bodies, although their views on the optimal corporate form and the need for an independent regulator/purchaser either differ or are unclear. The Alexandra and District Ambulance Service seeks a continuation of current operations for a period of at least two years.
- The Epworth Hospital believed that emergency cases should remain in Government hands and be centralised.
- A number of rural health services were concerned that competition and private providers of emergency services may lead to negative impacts on consumers, and generally favoured government monopolies.
- Private providers generally opposed the maintenance of government monopolies for ambulance services, but some noted that government providers for rural areas may have advantages, at least in the medium term.
- AOTC argued that there was no evidence for enhanced outcomes from competition in ambulance services and, for reasons of efficiency, equity and access, ambulance services should remain as a public agency.

Conclusions

This model does not adequately meet the assessment criteria, and is not recommended.

Statutory Authority with Ring–Fenced Business Unit (Model 2)

Description

This alternative is similar to Model 1, except that the provider 'business' function is ring–fenced in a separate internal business unit, with a degree of management autonomy and with clear accounting separation. This provides a half–way house between Model 1 and a full purchaser–provider split. There could well be a number of separate internal business units.

Issues

Issues raised are similar to Model 1; however, competitive neutrality concerns may be reduced by the internal separation of the provider function.

Stakeholder Views

- MAS noted that its current structure resembles a combination of this model with significant contracting out of non–emergency and support services (ie, Model 6, the unbundled service contracts model). MAS broadly supported continuation of this structure, but with the adoption of a more commercial governance structure and charter. It also argued for clarification of regulatory responsibilities, particularly with regard to clinical standards. Responsibility for setting high level standards should lie with the Department. MAS strongly argued for a single public emergency service provider on the grounds of accountability and public confidence, operational efficiencies and economies of scale, and effective management of response to major disasters.
- A number of private providers raised concerns about the fairness and transparency of pricing by ambulance services.

Conclusions

The main advantage of 'ring–fencing' is the scope it provides for more efficiently and transparently operating a business activity alongside regulatory functions. This review, however, has argued that having a regulator/purchaser that is structurally separated from any provider is necessary for effective competition. If the regulatory functions are split from MAS, then there is little justification to apply this model to the remaining provider business compared to the further business focus and competitive neutrality advantages that can be gained by moving to a government business enterprise structure (ie, Model 3). This structure is therefore not recommended.

This structure could, however, serve as an early transitional structure on the way to one of the later options because a number of businesses or regulator/purchasing functions could be set up as ring–fenced internal units and tested prior to separation and corporatisation.

Purchaser and Provider (Model 3)

Description

Under this alternative, there is a clear split between the purchaser/regulatory role and the provider role. The purchaser/regulatory role would be undertaken by the Minister and the

Department. The Minister would be responsible for high level policy and approvals. The Department would be responsible for more detailed development, monitoring and oversight of agreements with providers. The provider role would be undertaken by a single separate entity, in the form of a corporatised Government Business Enterprise (GBE) or a private provider. A service contract would exist between the purchaser and the provider.

Issues

Competitive neutrality concerns would be reduced and commercial focus would be improved as a result of the clear separation of the purchaser and provider roles. However, a single major provider implies a monopoly licence of some kind, and this would significantly limit competition. Competitors would effectively be confined to niches. Some competition could be provided for by putting the licence out to tender on a periodic basis. This alternative would probably suit the case where there are strong synergies and economies of scale and scope in the provider's operations that may be lost under more disaggregated models.

Essentially, this would provide an incentive structure that is likely to favour efficiency compared with earlier options. There would, however, be significantly less competitive pressures than Models 5 and 6. In addition, locating what would probably be a high level regulatory and purchasing role with a Department may have a number of disadvantages:

- It would not be at arm's length from government.
- It would not be as closely engaged with industry.
- It would probably not have the specialist knowledge and capabilities to overcome the information asymmetries with the monopoly provider.

A specialist independent regulator/purchaser would not have these disadvantages.

Corporatisation would probably require at least three to six months to implement. While this would be a significant task for management and the organisation, the process itself is well understood and holds few risks. There would be a very low likelihood of operational disruption other than possible industrial disruption. The implementation of this model as a single private provider would be a different matter. It would take longer and would be significantly more complex, and would involve a choice between a range of sale and tendering strategies. The corporatisation of the body and the development of the regulator/purchasing framework would be necessary before the sale process could commence. Unless managed very carefully, there would be a risk concerning operational continuity, industrial disruption and impaired public confidence.

Stakeholder Views

- MAS was generally supportive of such an option if the Department was limited to the role of a regulator and high–level purchaser and the emergency service provider remained as a public body. MAS's reasoning was similar to that outlined for Model 2 above. MAS noted that a contracting for a single private provider could introduce an element of serial competition, but would be likely to result in an effective private monopoly. There would be a risk that vertical integration issues would arise and that less commercially attractive services would be neglected. Financial failure of the private provider could have catastrophic consequences. There are significant public confidence issues associated with a single contract model.
- VPT favoured this model for the initial phase of reform with one important change; the introduction of competition through one large company in the initial phase. Model 3 was favoured over Model 4 in order to minimise the bureaucracy required to manage the system.

Conclusions

As noted above, this structure suits a business that displays very strong economies of scale. This appears not to be the case with ambulance services, especially in the metropolitan area. It provides for a more commercially–focused business, but not for competition or a more independent and sophisticated purchasing role, both of which offer significant benefits. This option is not recommended.

Detailed Purchaser and Provider (Model 4)

Description

This is similar to Model 3 in that there is a single major provider at the operational level. However, there is an additional layer of detailed purchaser and specialist regulator. The Minister would be responsible for high level policy and approvals. The Department would be responsible for the high–level development, monitoring and oversight of agreements with the detailed purchaser (which would probably be a statutory authority analogous to one of the Health Care Networks). The agreements would outline the funding arrangements for the purchase of certain generally high–level outputs, as well as performance benchmarks and associated reporting requirements.

The purchaser would enter into more detailed contracts or agreements with the provider (a GBE or a private provider). This model can be useful where there are significant complexities and day–to–day details in managing contracts with providers that would be best managed by a dedicated body. An example of this model is the set of relationships between the Government, a Health Care Network and a hospital.

Issues

Model 4 displays similar benefits to those outlined for Model 3 in terms of improved business focus, greater competitive neutrality and the introduction of competitive pressures from periodic re–tendering. In addition, the model has the advantages of a more sophisticated and independent purchasing role. A specialised purchaser would be better positioned to develop detailed contracts with appropriate incentive mechanisms and to monitor for underlying performance while remaining at arm's length from the political process and from competing priorities within departments.

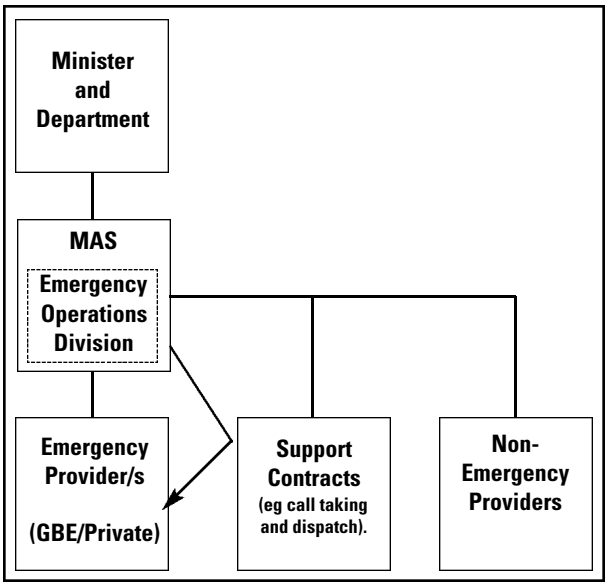
This model is suited to the case where there are strong economies of scale and scope which mean that a market can only be efficiently served by one provider. In the case of certain rural areas, this may well be the case. In the case of the metropolitan area, if the call taking and dispatch function is undertaken by an independent contractor, there does not appear to be major economies of scale or scope in emergency operations. It seems likely that the market is large enough to support more than one provider (and perhaps 3 to 6) each of which could operate at a reasonably efficient scale.

There is, however, a significant degree of uncertainty about the optimal number and shape of the emergency businesses into the future. There may be advantages in focussing initially on the establishment of an improved regulatory and purchasing framework before considering major structural changes to emergency operations. A single GBE structure would allow future options to be piloted and tested before consideration of implementation. For example, a number of internal business units could be established and be able to be benchmarked against each other. A single GBE structure would also be less likely to raise major workplace relations or public confidence issues.

In the longer term, periodic re–tendering of a single major licence, while better than a perpetual monopoly, does have its limitations. A monopoly provider would have strong information advantages over those who might contest for the major licence, as well as over any niche competitors. In addition, if an incumbent GBE does not win a tender then there may be significant transition costs to government associated with reducing the unneeded capacity unless the winning tenderer was required to take over certain existing staff and assets as part of the tender. In general, the gains from competition would be expected to be lower and slower than for more disaggregated models.

It is important to stress that Model 4 does not represent a radical departure from the current arrangements. In the metropolitan area, a single specialist government authority responsible for detailed purchasing and standards and contracting centralised dispatch (ie, MAS) would be retained with the only major change involving placing emergency operations into a separate body (see Figure 5.3). In rural areas, it would provide the perfect vehicle for the consolidation of the gains from the amalgamation.

Figure 5.3 Model 4 requires only modest structural changes



Stakeholder Views

- MAS supported the need for clear medically authorised protocols on a statewide basis, but favoured the regulatory/purchasing role remaining within the Department and being limited to a high level function. It argued that the additional costs associated with a larger regulatory entity should be avoided. Other comments relating to this model were similar to those on Model 3.
- ASV South Eastern strongly supported the establishment of a well–resourced independent regulator/purchaser.
- ASV South Western believed a legislative monopoly is necessary for emergency and urgent ambulance services, but was silent on the need for an independent regulator/purchaser.

Conclusions

An improvement on option 3 from the addition of an independent regulator/purchaser. It may be suited to some rural areas that can only support a single provider but in other areas competition may be unnecessarily restricted by a single provider. However, a single rural ambulance service represents a good interim option to allow the gains from the rural amalgamation process to be consolidated (eg, greater consistency of practice) before consideration of future options.

This model is a significant improvement on Model 3, given the benefits arising from a more independent and sophisticated purchasing role. As a longer term proposition, the model is best suited to markets which can only support a single provider, such as is likely for some rural areas. For other markets, such as the metropolitan area, a structure which provided for only a single provider may unnecessarily restrict competition.

It should be noted that some competition benefits are potentially available even with a single provider. For example, a single government emergency provider might divide operations into a number of ring-fenced internal business units and use best practice benchmarks to drive 'competition by comparison' between these units.

If one of the more competitive models discussed below is favoured, then this model may provide a good interim structure. In the case of a single rural ambulance, this would allow the gains from the amalgamation of the rural ambulance services to be consolidated before consideration of the optimal longer term rural structure. A single metropolitan provider (perhaps with a number of benchmarked internal business units) is also an interim option for the metropolitan area if a gradualist approach is preferred in moving to multiple major providers. This would provide for a smooth transition to a new regulatory and purchasing framework and the scope to explore and test a range of possible future structures before phasing in an optimal longer term metropolitan structure. Niche competitors could be allowed to provide part of the (single) overall service from an early stage.

Multiple Geographic Franchises (Model 5)

Description

This alternative is a variant of Model 4 under which there are multiple providers that are responsible for providing services in specific geographic areas. Boundaries might be 'strict' or 'porous'. The US provides examples of geographic franchises often with 'strict' boundaries, where a government or private provider may have the exclusive rights to operate ambulance services within, say, county boundaries.

Issues

Similar to Model 4, but with increased competitive pressures from the opportunity to benchmark between different franchises, and more

competition for tenders from established players. This could be achieved in the initial stages by dividing MAS into a number of sensible sized businesses, say three to six, in line with the approximate size of its internal operational units. Additional providers could be introduced over time as new areas of demand open up or as existing franchises come up for tender.

If the boundaries are 'strict' (ie, they do not allow the free flow of resources in line with overall system needs), then this would introduce significant problems in relation to operational inefficiency and service quality.

If the boundaries were 'porous' and/or if the boundaries corresponded to natural boundaries of population or geography, then this model would be significantly improved in terms of the operational and service quality criteria. One concern would be that, within a boundary, there would still be the opportunity for at least some unbundling, such as already occurs in relation to First Responder program, private providers serving sporting events, patient retrieval services and the use of the non–emergency providers. However, if some unbundling of the emergency effort were to occur — ie, the overall call taking and dispatch system tasked the unit best able to respond, regardless of boundaries — then this model would become very similar to Model 6.

Given the Government's decision on rural amalgamation, this model would not apply within rural areas in the medium term. However, in the longer term, after the gains from the amalgamation were consolidated, then it could be a viable option.

Stakeholder Views

- MAS strongly opposed this option on the grounds it would introduce significant boundary issues if it were applied to the metropolitan area, where there are no natural boundaries of population and geography. A franchise approach would also highlight equity issues unless rigorously regulated. Financial failure of a franchisee would have a major impact. It argued that a franchise system is inherently inefficient because it introduces unnecessary boundaries and complexities into the delivery of services.
- ASV South Eastern argued that emergency response by contractors is feasible with the correct regulatory and purchasing framework, and with exclusive geographic franchises for a specific period of time. However, it claimed that a private contractor may find it difficult to sustain community engagement in rural areas.
- ASV North Western believed that there should be no change in the current structure of ambulances service providers in rural areas (presumably meaning a single provider for a given rural area), and noted that an independent purchaser/regulator has some merit. Contracting mechanisms are possible, but there are doubts about the viability and community acceptance of private contractors.
- St. John Ambulance favoured some variation on Models 5 and 6. In its view, single area franchises of economic size will provide a basis for contestability and comparison between providers, whilst avoiding confusion through a single independent dispatch operator. Nevertheless, there must be a single point of access to the emergency 000 number, along with the establishment of porous geographic boundaries. Some elements of the existing ambulance service would be best unbundled prior to creation of regional contracts with periodic contestability. It argued that there should be a statutory authority with a purchaser/regulatory role but it should be open and flexible requiring minimal administrative structures. Moreover, it should avoid overly prescriptive standards that stifle innovation and promote an adversarial relationship with providers.
- A number of private providers believed this model was viable, if the boundaries were flexible.

Conclusions

A multiple geographic franchise model with 'strict' boundaries would introduce significant problems in relation to operational inefficiency and service quality and is not recommended.

A multiple geographic franchise model with 'porous' and/or natural boundaries of population or geography which allowed for some unbundling of services within those boundaries would be very similar to Model 6 (discussed below).

Unbundled Contracts (Model 6)

Description

This is a more sophisticated version of Model 5, under which the ambulance service is a single system controlled by a single authority but service provision is unbundled into a number of elements. These may be operational capabilities or support services that are put out to tender on say a three to five yearly basis.

Operational units (providers) may base their resources in a particular geographic area, but would not be strictly limited to that area. Rather, they would be contracted to respond to centrally coordinated dispatch orders and protocols across a potentially very wide area, but on the understanding that they would particularly focus on ensuring cover for a given base area. The emergency response effort may be unbundled, depending on the nature of demand in a given area, with First Responders, single responders, conventional ambulances and possibly other units contributing to an efficient mix of resources. These resources may be owned and operated by a number of government or private providers. Support services (such as vehicle maintenance and communications) could also be tendered out, and could serve a number of providers. Small local examples include the MAS contracting arrangements for the Cranbourne area and the First Responder program. An example of how this model might apply in the metropolitan area is provided as follows. MAS would be divided into a regulatory/purchasing function (which would be an independent statutory body to control the system as a whole) and a number of separate businesses (which would be corporatised GBEs). There would be more than one (and possibly three to six) emergency businesses and probably one or more support businesses. The emergency businesses would each be of a minimum efficient scale, be based in a certain geographic area and hold a contract with the regulator/purchaser to provide emergency ambulance services from this area under centrally coordinated dispatch. Support services (e.g. fleet maintenance, equipment maintenance, etc) would initially be provided to each business by a mix of one or more support businesses and allocations from existing contracts with outsourced suppliers.

Over time, each business would have the freedom to tailor its own operations and support arrangements as long as they remained consistent with the necessary standards, quality assurance and contract conditions. The independent regulator/purchaser could negotiate on behalf of the businesses for support services if this was seen as necessary (such as in the case of call taking and dispatch). The regulator/purchaser would also license other elements of emergency response such as First Responder, medical retrieval and non–emergency back–up. Additional providers could be introduced over time through competition for new areas of identified demand or for the existing contracts as they expire.

Issues

There is scope for introducing controlled competition in the emergency response in the metropolitan area without compromising operations. Public and private providers could competitively tender to undertake various elements of an integrated emergency response effort. There appears to be scope for a number of both emergency and non–emergency providers, as well as for providers of support services.

In the case of Rural Ambulance Victoria, in practice, there may be scope for only a single significant provider in a number of areas — possibly, although not necessarily, a government provider. In addition, issues of community engagement will be more significant, as will issues of integration with other emergency services or the health sector more generally. It seems likely that ambulance services that are 'bundled' with other emergency or health services may be attractive in many rural areas. Provider alternatives that best combine elements of both the competitive and cooperative approaches would be likely to be favoured.

If multiple emergency providers were introduced in suitable areas, patients and the public would not notice any major change to services on the ground. Asingle emergency 000 number would remain, providers would use similar vehicles, equipment and livery, officers would have the same training and be subject to the same basic set of operating protocols and standards, and pensioner concessions and subscriptions could continue. Under this model, efficiency would be likely to improve and

service quality would be no worse and might be significantly better. The comparison with a health care network is a good one; the existence of the network is not apparent to the patients or to the general public, but the network is free to purchase services from a range of health providers (mainly hospitals) to provide the most effective mix of services on behalf of the community.

Stakeholder Views

- MAS strongly opposed this option for the reasons outlined previously in support of a single public provider. Given the nature of emergency services, issues of accountability and public confidence are of particular significance. Operational efficiencies and economies of scale also favour a single provider. Coordination of resources is a key requirement for efficient response. While independent service providers could in theory be coordinated via the call taking and dispatch system, such an approach is fraught with the potential for conflict and failures of communication. The degree of central control required would undermine any potential benefits from competition. Duplication of administrative structures and the resources required to ensure cooperation would be a significant extra cost burden.
- MAS indicated that an increased role for first responders is expected in the future, but pointed out that first responder skills are relevant to only a very small cohort of patients (approximately 2.5% of emergency cases). First responders will be most effective if coordinated through a single emergency service provider. MAS argued that while single responders can be very effective, they are best suited to areas of high demand. Use of single responders may be inefficient elsewhere, because of the requirement for a minimum three officer/two vehicle response (rather than the conventional two officer/one vehicle response). A single service provider is in the best position to decide on the appropriate deployment strategies, based on analysis of the clinical, operational and financial factors.
- MAS noted that sub–contracting by a single service provider would be a workable model, similar to the Cranbourne arrangements. It argued that the service provider for Melbourne should have the capacity to sub–contract or use in–house resources based on an assessment of the options. Wider application of sub–contracting would need to deal with system integration and public confidence issues.
- Rural ambulance services generally argued that unbundling of ambulances services, while theoretically possible, is unlikely to be cost effective in many rural areas and that private contractors may not be able to sustain community involvement.
- Inner and Eastern Health Care Network favoured a purchaser–provider split and strengthening the role of purchasing with priority attached to quality monitoring, the development of output based funding mechanisms and system integration. This may also involve the establishment of a separate purchasing entity at arm's length from government with oversight retained by government in the transition stage of purchasing reforms. There should be flexibility to enable the transition to occur from single provider to multiple providers at a later date.
- Southern Health Care Network believed there ought to be the ability to introduce 'controlled' competition in emergency response in the metropolitan area, with private providers tendering to undertake various elements of an integrated emergency response effort. It would be impossible to undertake market testing when there is only one provider as at present but, in the future, staged market testing and transitional arrangements could be undertaken.
- The Alfred Hospital believed that there are benefits in the Act facilitating a greater role for medical retrieval services as part of the overall emergency response effort.
- VPT strongly favoured a competitive unbundled model with an independent purchaser regulator but noted that this was more suited to a more mature industry after a transitional phase. No matter which model is chosen, it is imperative that work–flows are not compromised by geographic or demographic restriction. It further argued that there should be a staged introduction process commencing in the more buoyant market of the metropolitan area, with subsequent roll–out to metropolitan fringe areas, regional centres and finally rural areas.
- A number of other private providers believed this model was viable. Some believed that separation of the transport and clinical elements was also viable in a range of urban areas. Some noted that oversight and contracts should not be too restrictive, else this will restrict innovation and service quality.
- St. John Ambulance argued that certain services for major emergencies may be more efficiently unbundled under contract to a specialised provider.
- TAC opposed the fragmentation of the emergency response effort and the introduction of multiple emergency providers.

- Workcover also had concerns regarding the fragmentation of emergency response effort.
- In relation to the emergency response, DVA noted the view that fragmentation to take advantage of increased competition, if taken too far, could jeopardise the whole operation.
- Racing Victoria strongly supported this model as a good balance between competition and effective regulation.
- BEST generally supported a competitive model and noted that two service providers could undertake emergency ambulance services in the metropolitan area and probably beyond. It argued it was inappropriate for MAS to be both purchaser and provider — it should be one or the other. Independent computer aided dispatch has provided the basis for competition and performance monitoring. Without some form of competition in the delivery of emergency ambulance service in the metropolitan area, there was unlikely to be any further reduction in response times without additional resources from government.

Conclusions

This model allows for the maximum expression of competition and efficiency within a tightly coordinated system, subject to effective regulation and sophisticated purchasing which ensures that service quality and equity concerns are properly addressed. It is very flexible, and one system could encompass the entire State. For these reasons, it is recommended as the preferred future model.

This model, however, is more difficult to implement than the other alternatives, and would require a phased approach with some transitional structures, allowing for testing at each stage; and with a differentiated approach between the rural and metropolitan areas. These issues are covered in Section 5.3.

Recommendation

- The Allen Consulting Group recommends that a future industry structure should, as a minimum, go to Model 4. However, the policy should allow for a possible transition to Model 6 if detailed business assessments demonstrate that a number of operational units of efficient scale would be capable of operating as independent provider businesses within the single system, with a high degree of assurance that service standards and quality would remain uniformly high or improve. The detail on the exact structure and timing of such a transition would be determined only after careful assessment in the earlier phases of the reforms. Model 2 would provide a useful structure within which potential new structures could be tested and developed prior to new legislation being enacted.

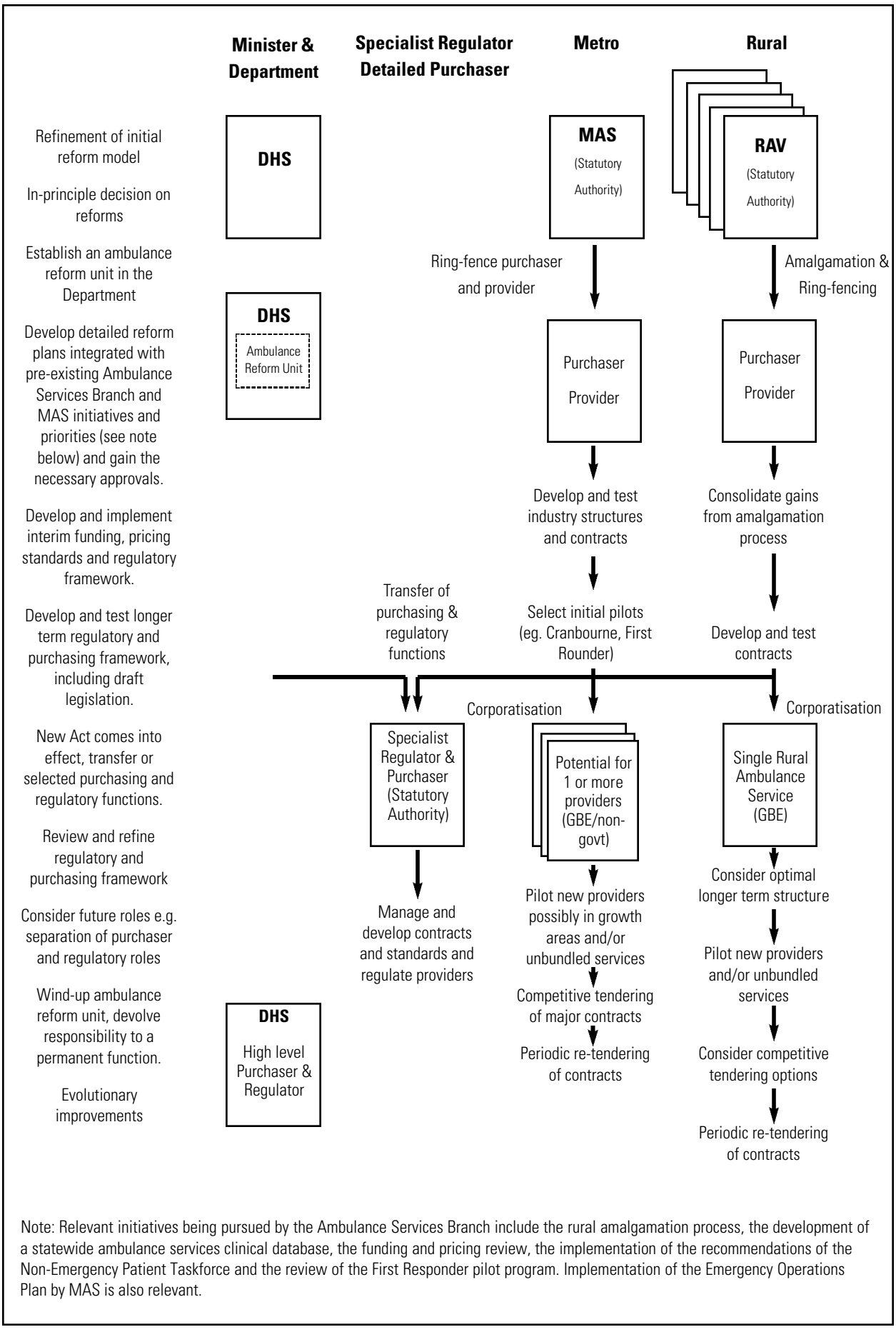
5.3 Managing the Transition

While it is important to have a clear idea of the desired final industry structure, complex structures cannot be implemented overnight. Any change to an industry structure will not be without risks, and these risks will need to be managed effectively during the transition. Therefore, in practice, it is likely that any proposed changes will need to be phased in over a transitional period of a number of years to enable the necessary work is done to ensure continuity of service, and maintenance of public confidence.

An indicative transition pathway is provided in Figure 5.4. As the figure illustrates, a staged implementation process for a change in the structure of ambulances services could take the following approach:

- Refinement of the initial reform model after careful analysis during the early phases of the reforms.
- Development of detailed reform plans integrated with pre–existing Ambulance Services Branch and MAS initiatives and priorities, gaining the necessary approvals.
- Development and implementation of a framework for interim funding, pricing standards and regulation.
- Development and testing a longer–term regulatory and purchasing framework, including the drafting of new legislation.
- The new legislation comes into effect, with the transfer of selected purchasing and regulatory functions.
- The new regulatory and purchasing framework is reviewed and refined.
- Implementation of evolutionary improvements.

Figure 5.4 Indicative Transition Pathway



Note: Relevant initiatives being pursued by the Ambulance Services Branch include the rural amalgamation process, the development of a statewide ambulance services clinical database, the funding and pricing review, the implementation of the recommendations of the Non-Emergency Patient Taskforce and the review of the First Responder pilot program. Implementation of the Emergency Operations Plan by MAS is also relevant.

5.4 Assessment of the Models Against the Key Criteria

Tables 5.1 and 5.2 provide a summary of the analysis contained in Chapters 4 and 5 in terms of the criteria presented in Section 5.1 (see Box 5.1 in Section 5.1 for an explanation of the assessment criteria).

The key for the tables is as follows:

+ Provides *some support* for the criterion
++ Provides *strong support* for the criterion
+++ Provides *very strong support* for the criterion

Table 5.1 Assessment of Criteria — Metropolitan Area

	Status Quo Metropolitan Ambulance Service	Model 1: Single Statutory Authority	Model 2: Statutory Authority with Ring–Fenced Business Unit	Model 3: Purchaser and Provider	Model 4: Detailed Purchaser and Provider	Model 5: Multiple Geographic Franchises	Model 6: Unbundled Contracts
Service Quality	++	++	++	+/++	++	+/++	++/+++
Access & Equity	++	++	++	+/++	++	++	++
Technical Efficiency	++	+	++	+++	+++	+/+++	+++
Allocative Efficiency	+	+	++	++	++	+/+++	+++
Dynamic Efficiency	+	+	++	++	++	+/+++	+++
Impact on Budget	+	+	+	+/++	+/++	+/++	++
Ease of Implementation	+++	+++	++	+/++	+/++	+	+

Table 5.2 Assessment of Criteria — Rural Areas

	Status Quo Rural Ambulance Services	Model 1: Single Statutory Authority	Model 2: Statutory Authority with Ring–Fenced Business Unit	Model 3: Purchaser and Provider	Model 4: Detailed Purchaser and Provider	Model 5: Multiple Geographic Franchises	Model 6: Unbundled Contracts
Service Quality	+/++	++	++	+/++	++	+/++	++/+++
Access & Equity	+/++	++	++	+/++	++	++	++
Technical Efficiency	+/++	++	++	+++	+++	++/+++	++/+++
Allocative Efficiency	+	+	++	++	++	++/+++	+++
Dynamic Efficiency	+	++	++	++	++	++/+++	+++
Impact on Budget	+	+/++	+/++	+/++	+/++	+/++	++
Ease of Implementation	+++	++	++	+/++	+/++	+	+

5.5 Other Issues for Consideration

Synergies and Integration

In parallel with these broad structural alternatives, opportunities for closer integration with other emergency services and the health sector also need to be considered. This could take a range of forms including cooperation, co–location or complete integration. Such resource sharing possibilities are particularly important in rural areas where economies of scale can mean that stand–alone services can be expensive and under–utilised. There are also opportunities in the metropolitan area.

There is already a policy of considering co–location with other emergency services where new facilities are being built. In Victoria, there are currently between 20 and 30 stations co–located with other health and community service facilities, and further co–locations are planned. Greater service integration is also a possibility. In the US, there are numerous examples of fire services also providing ambulance services, and the Victorian First Responder pilot program has been noted.

Unlike other health care occupations, ambulance services have traditionally not been well integrated into the broader health system. This may have something to do with the volunteer origins of ambulance services, and the strong support for ambulance services demonstrated by local communities, particularly in rural areas (see below). However, with the trend towards professionalism, it seems that there may be significant advantages from the greater integration of an ambulance service with a local health care facility:

- **Skills** – with clinical skills, it is often a case of 'use it or lose it', and the hospital environment would provide significant opportunities for training and skill maintenance and development.
- **Facilities and overheads** – can often be shared.
- **Incremental work** – from utilising the downtime of ambulance officers.
- **Scale** – in small communities that would otherwise only have one–officer crewing, it can provide opportunities for two–officer crewing through using a nurse, doctor or emergency driver from the hospital staff to complement the ambulance officer.
- **Relationships** – can provide for greater understanding and relationship building, and better service outcomes from a familiar, dedicated team.
- **Social issues** – can provide a potentially more challenging and enjoyable working environment that is important in attracting and retaining skilled staff, particularly in smaller towns.

There are also strategic considerations. Hospitals are becoming more integrated with their communities — for example, there is increasing emphasis on more numerous shorter stays and outpatient services, hospital in the home, district nursing and community health services. Ambulance services would provide a natural conduit into the community. In smaller towns, which may not have a hospital or a doctor beyond emergency and non–emergency transport roles, the ambulance service could fulfil a number of roles, including the first line carer.

There are also potential disadvantages to integration, including the impact of the location and ease of access to hospital sites, and the impact of incremental hospital work on response times. In addition, there is the potential loss of resources or focus on the core emergency response activity.

These integration possibilities can be accommodated with the preferred model. Fire services could tender to provide aspects of emergency response, or could enter into resource sharing deals with ambulance services. Local hospitals or health networks could tender to provide ambulance services, or more likely enter into an alliance, joint venture or partnership arrangement with an ambulance service.

Recommendations

- Opportunities for closer integration between ambulance services and other emergency services and the health sector should continue to be explored.

Community Engagement

It is also important that the structural alternative chosen can provide scope for engagement with the community. The CFA provides a good

example of community involvement. Such initiatives can be critical components of services in rural areas. There are many examples of existing community activities which support ambulance services, including volunteer officers or drivers, local auxiliaries and fund–raising activities, first aid training and awareness activities in the community, and trained first aid and emergency response volunteers in major workplaces or shopping centres. In any analysis of different models, it is important that the benefits of maintaining community engagement are fully factored into that analysis.

There are also clearly constraints on the use of volunteers. It can affect response times and may dilute the desired clinical or operational training and standards.

Community engagement is entirely consistent with the preferred model. In rural areas, government businesses would be retained, at least in the medium term. In the longer term, there would be scope for exploring whether private contractors, such as those that currently operate successfully at Cranbourne, are viable in certain areas. Competition and cooperation can co–exist. Ambulance providers building long term relationships or partnerships with their communities can provide advantages to all parties in terms of offering a higher level of service at a lower cost than a strictly commercial operation. Alternatively, there may be scope for largely community–based organisations to provide services in some areas, perhaps supported by an emergency service or a hospital.

Recommendations

- It is important that scope for, and impact on, community engagement is carefully considered when introducing an alternative structural model for the ambulance service, particularly in rural areas.

Adequacy of Contractual and Regulatory Mechanisms

There are costs to the purchaser and the provider related to establishing, administering, monitoring and reviewing a service contract or agreement — these are known as 'transaction costs'. In addition, there are risks for contracting parties in terms of the different incentives for, and interests of, purchasers and providers and the ability to contract around them — these are known as 'principal–agent' problems. In some cases, these transaction costs and risks can be minimised by providing the service in–house. However, there may be a trade–off in terms of other parameters such as cost, efficiency, service quality or innovation. In other cases, services can be efficiently purchased in a competitive market, or by negotiation between mutually interested parties, such as through a strategic relationship, joint venture, partnership or alliance. In the area of human services, many services are not provided under a competitive model, but rather as a cooperative venture — often between the Government, the community and perhaps not–for–profit bodies. Clearly, central to the choice between alternative structures will be the trade–offs between these transaction costs and the risks and other costs and benefits of these models.

At a practical level, it is clear that these are complex services to specify and monitor. Whilst this can be done, great care would need to be taken in terms of regulatory design, contract development, phased market testing and transitional arrangements. The complexity of the purchasing role, and the need for a strong focus on the purchasing role at arm's length from Government, suggest the need for at least two levels of purchaser. The Government would set the broad policy and regulatory environment and be the high–level purchaser and funder. A statutory body would be the specialist purchaser/regulator responsible for overall coordination, establishing standards (with the industry) and sourcing services from providers, and would have reserve powers to direct in certain situations. (There could be higher level reserve powers for Government.) Given the limited expertise available, and the need to avoid unnecessary duplication, there is a good case for a single dedicated regulator/purchaser which could be formed from elements of MAS, Rural Ambulance Victoria and the Government.

The regulator/purchaser would be responsible for facilitating the development and implementation of industry standards. In fulfilling this role, it should rely to the greatest extent possible on industry input in developing standards through consultative arrangements, industry developed

standards, accreditation and codes of practice. This may cover such issues as:

- Clinical standards, protocols and auditing.
- Call taking and dispatch and other operational procedures.
- Equipment and vehicle standards.
- Training and qualifications.

Licensing/registration of providers would also be a function of the regulator/purchaser. A licence/registration would allow an ambulance service (which could be public, private or not–for–profit) to use warning devices under certain circumstances and the term 'ambulance'. The licensing system should be flexible enough to cater for different circumstances, such as: emergency; first responder; medical retrieval; public events; and non–emergency. Each licence type would be required to comply with certain industry standards and regulatory requirements. Purchasers of ambulance services may require operators to gain appropriate registration as a condition of a contract.

Given the move to a more competitive model it is appropriate to establish occupational registration. The purpose of this registration is to protect the public in cases where health practitioners are placed in position of trust. An Ambulance Officers Registration Board should be established along the lines of the Victorian model of health practitioner registration:

- An independent, self–funding Board appointed by Government to administer occupational registration of ambulance officers for the purposes of protection of consumers.
- Protects the use of certain titles (eg, 'Registered Ambulance Officer') at a number of appropriate levels to those with the appropriate accredited qualifications and experience.
- Provides for disciplinary and complaints handling provisions.

It may be that purchasers of ambulance services require operators to use employees with appropriate registration as a condition of a contract.

Recommendations

- The Department should set the broad policy and regulatory environment and be the high–level purchaser.
- A statutory body formed from elements of MAS, Rural Ambulance Victoria and the Department should be the specialist purchaser/regulator responsible for overall coordination, establishing standards (with the industry) and sourcing services from providers, and should have emergency management coordination role.
- Licensing/registration of providers should also be a function of the regulator/registration. This should allow an ambulance service to use warning devices under certain circumstances and the term 'ambulance'. The licensing scheme should be flexible enough to cater for different circumstances, such as emergency, first responder, medical retrieval, public events and non–emergency.
- An Ambulance Officers Registration Board should be established along the lines of the Victorian model of health practitioner registration.

Funding and Pricing

The ability to intervene and set prices clearly restricts competition. However, given the monopoly position of ambulance services, price controls might reduce the scope for monopoly pricing and so be in the public interest. Even if a monopoly structure is desirable, competition can still be used in terms of the Government acting as a purchaser on behalf of the public, and providers bidding against each other to undertake the service through a competitive tender. There are two basic alternatives: prices could be set by Government and tenderers could compete on the basis of service, or the Government could specify the service and the tenderers could compete on the basis of price. For these options to work, standards required for ambulance services must be able to be effectively specified and their achievement monitored.

In reality, the public is paying for a high degree of reserve capacity, especially in rural areas, to ensure that a state–wide emergency response service of an appropriate standard is available in event of an emergency. In such a case, a large

fixed component in a contract may be appropriate, effectively representing the purchase of 'insurance'. At the same time, it is important to retain some incentive for the provider to meet incremental demand. A pricing structure with fixed and variable components (perhaps subject to a cap or steps, and with escalation clauses and incentive mechanisms) would be attractive in terms of minimising overall costs and optimising the risk sharing between the purchaser and the provider. If competitive tendering is used, then the service — and probably the broad pricing structure — would need to be defined, with the detailed price determined through competition between bidders. Alternatively, bidders might wish to provide additional or higher quality services to differentiate themselves from their competitors.

Recommendations

- The regulator/purchaser should regulate the prices of emergency ambulances services.
- Pricing structures with fixed and variable components are recommended. This could be subject to a cap or steps, and include escalation clauses and incentive mechanisms.

Facilities

In moving to a more competitive model, does the ownership or control of certain facilities provide a restriction on competition? The significant investment required to enter the market (particularly the emergency response market) combined with potentially a limited contract period and uncertainty regarding future contracts may deter new entrants. However, the Government currently owns or controls all of the facilities, and so use of existing facilities and equipment could be made a condition of a tender. An issue for the future might be the extent to which such facilities and equipment would revert to the Government at the end of a contract period and under what conditions.

6. THE REGULATORY AND PURCHASING FRAMEWORK

Key Points

- The proposed regulatory and purchasing framework required to underpin the preferred model contains five main elements:
  1. High Level Purchaser/Regulator — the Minister and the Department to oversee the regulator/purchaser and to provide funding conditional on the regulator/purchaser meeting a range of requirements.
  2. Specialist Regulator/Detailed Purchaser — a statutory authority governed by an independent board, with a number of key responsibilities for the control of the system — including detailed purchasing of an effective, efficient and equitable mix of ambulance services for the community; call taking arrangements; overseeing the subscriptions scheme; price regulation; setting conditions on contracts; development and implementation of industry standards; establishing registration/licensing of ambulance services; and coordination of emergency management planning.
  3. Government Ambulance Services — corporatised government business enterprises providing ambulance services on a commercial basis.
  4. Registered/Licensed Ambulance Services — allowing an ambulance service (public, private or not–for–profit) to use warning devices under certain circumstances and the term 'ambulance'.
  5. Ambulance Officers Registration Board — an independent, self–funding Board appointed by Government to administer occupational registration of ambulance officers for the purposes of public protection.

The current Ambulance Services Act contains significant restrictions on competition that are not justifiable on public interest grounds and the Act also does not support a best practice model for the provision of government services. The Act will require substantial change if it is to support the ambulance services of the future in a more complex and competitive environment. The new Act would be a sea change in ambulance services in Victoria and internationally. It would harness the best aspects of competition in a carefully regulated environment to provide the basis for significant improvements in the quality, responsiveness and efficiency of ambulance services in Victoria. It is a thoughtful and practical response to providing a best practice model for ambulance services of the future.

6.1 The Proposed Framework

An overview of the proposed regulatory and purchasing framework required to underpin the preferred model is summarised Table 6.1 below. The transitional phases of the reforms prior to the establishment of the regulator/purchaser (as outlined in Figure 5.3 in Chapter 5) do not require legislative changes, and appear to be capable of being implemented under the current Act.

Table 6.1 Proposed Regulatory and Purchasing Framework

Element	Role	Legal Form
High–Level Purchaser/Regulator	Minister and the Secretary of DHS or their delegate have the role of high–level purchaser of ambulance services. Provide funding to purchaser/regulator under certain conditions. Appointments to the Board and oversight of the organisation. Appointment of Ambulance Officers Registration Board. Treasury oversight of certain financial and commercial matters.	Powers and functions provided for in the Ambulance Services Act.
Specialist Regulator/ Detailed Purchaser	Specialist regulator/purchaser for the ambulance industry governed by an independent board with a specific charter composed of appropriately qualified persons including representatives from different sectors of the industry. Responsible for purchasing an effective, efficient and equitable mix of ambulance services on behalf of the government with a requirement to use mechanisms that enhance competition. Oversight of a subscriptions scheme. Price regulation of ambulance services, where they have significant market power. Ability to set conditions on contracts such as adherence to standards, franchise areas, etc. General control of the system. Responsible for the development and implementation of industry standards. Should rely to the greatest extent possible on industry input in developing standards through consultative arrangements, industry developed standards, accreditation and codes of practice. May cover such issues as: • Clinical standards, protocols and auditing • Call taking and dispatch and other operational procedures • Equipment and vehicle standards • Training and qualifications • Basic vehicle criteria Responsible for registration/licensing of ambulance services (see below). Coordination role in relation to emergency management planning.	Statutory corporation created under the Ambulance Services Act with powers and functions provided for under the Act.
Government Ambulance Services	Corporatised GBEs providing ambulance services on a commercial basis.	Corporatised GBE subject to corporations law style governance arrangements consistent with the Government's GBE policies.
Registered/Licensed Ambulance Services	A licence/registration would allow an ambulance service (which could be public, private or not–for–profit) to use warning devices under certain circumstances and the term 'ambulance'. There would be a number of different licences to cater for different circumstances, such as: Emergency; First responder; Medical retrieval; Public events; and Non–emergency. Each level would be required to comply with certain industry standards and regulatory requirements. Purchasers of ambulance services may require operators to gain appropriate registration as a condition of a contract.	Registration/licensing Provisions in the Ambulance Services Act.
Ambulance Officers Registration Board	Independent, self–funding Board appointed by government to administer occupational registration of ambulance officers for the purposes of protection of consumers. Protects the use of certain titles (eg 'Registered Ambulance Officer') at a number of appropriate levels to those with the appropriate accredited qualifications and experience. Provides for disciplinary and complaints handling provisions. Purchasers of ambulance services may require operators to use employees with appropriate registration as a condition of a contract.	Provisions in Ambulance Services Act consistent with the Victorian model of health practitioner registration.

6.2 Review of the Current Legislation

The current Act has a form which may have been suited to an environment where there was a range of ambulance services of differing capabilities that were subject to 'hands on' supervision by government. This approach is inconsistent with current best practice trends in government service delivery and legislative design. The Act requires substantial change if it is to support the ambulance services of the future in a more complex and competitive environment.

This section examines the provisions in the Act and provides a commentary on potential competition issues in the context of the preferred future model for the ambulance services industry in Victoria.

Key Aspects of the Review

Under a competition policy legislative review, the task is essentially:

- To identify potential restrictions on competition in the legislation.
- To assess whether the benefits to the public of the restriction outweigh its costs.
- To determine whether there are alternatives to the legislative restrictions that can achieve the same end.

As already noted, this review includes a requirement to examine at a broad level what competition policy issues might arise in applying current best practice models of government service delivery and regulation.

While the Act does not contain an outright ban on persons other than an ambulance service delivering emergency response services, it does have the effect, in concert with a number of other Acts, of severely restricting entry to this market. This gives the Government the opportunity to establish ambulance services as legislative monopolies. Entry to the emergency response market is severely restricted through prohibiting parties, other than an ambulance service (or in some cases its authorised sub–contractors), from:

- Representing themselves in any way as an ambulance service (section 39).
- Acting as an emergency vehicle in traffic, including the use of lights and sirens. (Provisions in the **Road Safety Act 1986** and *Road Safety (Traffic) Regulations 1988* apply to vehicles operated by or on behalf of ambulance services as defined in the *Ambulance Services Act 1986*.)

One of the greatest restrictions, however, is not stated directly in the Act — viz. that direct access to calls made through the emergency 000 telephone number is restricted to ambulance services (excluding calls made for non–emergency ambulance services). This is not to imply that these restrictions are not necessarily in the public interest. Rather, the issue is who should be allowed to be part of the emergency response.

Together, these provisions make it virtually impossible for a potential provider other than an ambulance service to provide an emergency ambulance response service. Aspects of emergency response effort remain contestable at the fringes, such as urgent inter–hospital transfers undertaken by medical retrieval teams (who provide, in conjunction with ambulance services, the clinical and sometimes the transport elements of the service, often in specialised areas such as neonatal or paediatric), and private medical transport providers that can undertake urgent inter–hospital transfers. Private and not–for–profit contractors can undertake a range of emergency and urgent response activities (eg, back–up in times of high demand, major emergencies and stand–by 'ambulance' services at public events), but only as a sub–contractor to, or under authorisation from, an ambulance service.

Under the Act, the Government has the ability to create ambulance services and control virtually every aspect of their operation. Some of the key provisions are:

- The ability to create, modify and abolish ambulance services (section 23).
- A role in overseeing virtually every aspect of an ambulance service (section 9) including wide powers to direct ambulance services (section 10).
- Powers to grant subsidies and impose conditions (section 12).
- Wide powers to make regulations in support of the Act (section 40).

As discussed in this review, such a high level of direct control over service providers is far from a best practice model for government service delivery.

Do the benefits to the public from a legislative monopoly for government ambulance services outweigh the costs to the public in restricting entry to the emergency response market? The question of what are public costs and benefits and how should they should be assessed was addressed in detail in the Victorian Government's Guidelines for the Review of Legislative Restrictions on Competition (1996). The National Competition Council has also addressed the question in its report entitled Considering the Public Interest under the National Competition Policy (November 1996).

Chapters 4 and 5 analysed the Government's objectives for the Act, the costs and benefits of the restrictions and the alternatives to regulation, and argued that the effect of the current arrangements is a substantial restriction on competition. A preferred industry model was identified that significantly reduces the restrictions on competition and meets the public benefits test. The regulatory and purchasing framework that underpins the preferred model is a substantial departure from the existing Ambulance Services Act.

The remainder of this section examines the specific provisions in the existing Act at a more detailed level in the context of the preferred model. For ease of comparability with the Act, the sequence in which issues are addressed is in the same approximate order in which they appear in the Act. Relevant provisions in other Acts are also discussed.

Purposes of the Act (Part 1)

Description

The purposes of the Act (as described in section 1) are general and mechanistic and do not explain the underlying objectives for the Act.

Conclusions and Recommendations

While not a competition policy issue, clear objectives in an Act clearly aid comprehension and interpretation.

(Note that Part 2 is to be repealed — see Section 2.4 of this report.)

Functions and Powers of the Chief General Manager (Part 3)

Description

Part 3 of the Act describes the functions and powers of the Chief General Manager (ie, the Secretary of DHS). Under the Act, the Chief General Manager's powers are delegated to the Director of Ambulance Services.

Part 3 largely defines the scope of the role envisaged for Government under the Act. While there is some overlap, this can be divided into a number of different roles:

- Policy formulation, advice and administration (s.9(a),(b),(k),(n),(o),(p),(u)).
- Performance monitoring and inspection (s.9(c) to (g), s.11).
- Management of ambulance services (s.9(h),(i),(l),(m),(r),(s),(t)).

In order to carry out these functions, a wide range of powers are provided for, including powers in relation to:

- Priorities (s.10(4)(a)).
- Training (s.10(4)(b)).
- Employees (s.10(4)(c)).
- Categories of patients to be attended (s.10(4)(d)).
- Facilities (s.10(4)(e),(f)).
- Coordination with the health sector (s.10(4)(g)).
- Accounts, records, budgets and forecasts (s.10(4)(h),(i),(j)).
- Intergovernmental agreements (s.10(4)(k)).
- Fees and subscriptions (s.10(5)).
- The granting of subsidies and the setting of conditions (s.12).
- Strong powers of inquiry, including taking evidence under oath (s.13).

The above functions and powers effectively provide the necessary legal machinery for the Government to perform roles ranging from high level policy to regulation to purchasing/monitoring and right down to the detailed management of the provider function. This largely reflects current practice since the Government does become directly engaged in a wide range of detailed management issues for ambulance services.

Issues

Many of the above functions and powers are designed for the effective control of the management and operation of ambulance services. In the main, they do not generally constitute restrictions on competition by themselves. However, as noted above, when taken together with other provisions in this and other Acts, they provide for a legislative monopoly for ambulance services.

The current powers and functions are at odds with the purchaser–provider model, which stresses a role for Government in setting policy, specifying outputs and monitoring outputs and outcomes. Under alternative structures, a range of similar powers might remain, but they would be split between a number of roles — policy, regulation, purchaser and provider. The main competition issue in regard to roles is that a clear split between purchaser/regulatory role and provider role could facilitate contestability by providing for the clear specification and monitoring of the services through a service agreement or contract, and by reducing conflicts of interest between roles.

Conclusions and Recommendations

These powers should be separated and restructured consistent with the roles identified in the preferred model.

Ambulance Services (Part 4)

Description

Part 4 of the Act provides for the functions, powers and governance of ambulance services. Essentially, ambulance services are governed by a committee of management appointed by the Governor in Council, together with a regional superintendent (ie, the CEO of the ambulance service) appointed by the committee of management with the approval of the Secretary, DHS. An important element in this Part of the Act is the statement of the objectives of ambulance services in section 15 (see Box 6.1).

Box 6.1: The Objectives of an Ambulance Service

The objectives of an ambulance service are to:

a) Respond rapidly to requests for help in a medical emergency.
b) Provide specialist medical skills to maintain life and to reduce injuries in emergency situations and while moving people requiring those skills.
c) Provide specialised transport facilities to move people requiring emergency medical treatment.
d) Provide services for which specialised medical or transport skills are necessary.
e) Foster public education in first aid.

Issues

Under the current model, ambulance services are statutory bodies that are required to interpret very broad objectives and make judgements about resources and management based on those judgements. At the same time, they are also subject to significant oversight and management by Government. This structure is one of the components that underpin the legislative monopoly of ambulances services.

Currently, ambulance services have both a purchaser and a provider function. Under a competitive model, if a statutory body was to be created to undertake the purchaser/regulatory role, then that body would need a charter, powers and governance arrangements. This body could contract for services with providers. If the service requirements were specified in a contract, then it may not be necessary to create a specific statutory body. If providers were privately owned, they could use an appropriate legal structure such as a corporations law company. If providers were government owned, a general purpose legal vehicle could be used, such as a state owned corporation. Such general purpose vehicles may provide advantages in terms of a more competitively neutral structure. This issue is discussed in more detail in the next section.

A general observation is that the objectives described in Box 6.1 are, in fact, the only part of the Act that attempts to define what ambulance services are, and thus the scope of Government intervention into the ambulance services market.

In a restructured Act, these objectives may provide a good starting point for describing the scope of the regulatory or purchasing roles.

Conclusions and Recommendations

Altered forms of these objectives may be more appropriately incorporated into the objectives of the regulator/purchaser.

Creation, Modification and Abolition of Ambulance Services (Part 5)

Description

Part 5 of the Act provides for the creation, modification and abolition of ambulance services. In particular, it provides for the specification of boundaries of ambulance services, confirms the legal status of the body, and provides for some special conditions in relation to the Alexandra and District Ambulance Service.

Issues

Again, this structure is one of the components that underpin the legislative monopoly of ambulance services — in particular, the ability to define boundaries within which an ambulance service has effectively an area monopoly.

As mentioned in relation to Part 4 of the Act, under the preferred model, specific purpose statutory bodies do not need to be established for providers as they will be corporatised GBEs. The regulator/purchaser role, however, is suited to a statutory body.

If general purpose vehicles were adopted, could these simply enter into contracts for service provision or would there also need to be some form of licensing? A licensing system might provide a useful framework for the imposition of required standards and conditions. Being able to meet the appropriate licensing conditions could be a pre–qualification for tenders. Such a system could facilitate competition by separating the provider from the area monopoly and potentially unbundling the monopoly and making the elements contestable. However, if competition turns out not to be viable, then such a system may well result in additional administrative costs.

The Alexandra and District Ambulance Service is different from other ambulance services in that it is almost entirely a voluntary organisation and receives minimal funding from Government. It provides a good example of some of the positive aspects of community involvement in ambulance services. There are a number of special provisions that make it more difficult to make changes to the arrangements for this ambulance service.

Conclusions and Recommendations

Under the preferred model, ambulance services would be corporatised GBEs or non–government providers and so objectives for them in ambulance legislation are not required.

Similar provisions, however, are required for the establishment of a single statutory authority to perform the role of the regulator/purchaser as described in the preferred model.

Ambulance Officers Training Centre (Part 6)

Description

As noted earlier, training of ambulance officers has traditionally been undertaken by the AOTC; however, ambulance officer training has now been mainstreamed, and the provisions of Part 6 are to be repealed.

Conclusions and Recommendations

The consultant is supportive of the mainstreaming of ambulance officer education. Under the preferred model, no provisions are required for government provision of ambulance officer training.

General Provisions (Part 7)

Description

These provisions include:

- The power to accept gifts (s.33).
- Controls on capital expenditure (s.34).
- Provisions for the appointment of an administrator (s.35).
- Provisions for committees of management of ambulance services to create by–laws (s.36).

Conclusions and Recommendations

Under the preferred model, ambulance services would be corporatised GBEs or non–government bodies. Such bodies do not require a specific power under the Act to accept gifts. Controls on capital expenditure by providers and provisions for the appointment of an administrator are also not required in the Act, as these would not apply

to non–government bodies and in the case of corporatised GBEs, would be part of their separate governance arrangements. Providers should not have the power to create by–laws; this is a regulatory function.

Offences (Part 8)

Description

Part 8 of the Act (ie, section 39) includes various provisions aimed at making it an offence to use the words 'ambulance service' or 'ambulance', or to do other things that may have the effect of representing a party as an ambulance service.

Certain organisations are exempt from these provisions — in particular, the St. John Ambulance (as a 'grandfathering' measure) and animal ambulances (where there can be no confusion that the operator is providing human ambulance services).

Issues

Given the nature of the emergency response function, there is a public confidence issue that there should be a minimal level of confusion for people seeking to contact an ambulance during an emergency. Moreover, the community has expectations regarding what kind of service such an ambulance would provide.

As part of a regulatory framework, it may well be that there is a need to provide for offences in relation to parties holding themselves out to be ambulance services. This clearly restricts competition, but it is justifiable in terms of public confidence benefits.

On the other hand, being able to use the words 'ambulance' or 'ambulance service' can confer significant competitive advantages on an organisation, particularly if ambulance services are to be contestable.

Under the preferred model, there would be a system of licensing/registration of providers which would allow any appropriately qualified providers to seek a licence/registration from the regulator/purchaser. This would enable the use of the term 'ambulance', the use of appropriate warning devices under certain conditions, and would commit the provider to certain industry standards and regulation. The licensing system should be flexible enough to cater for the various types of ambulance and other specialised services.

A competitive industry structure will also require some form of occupational registration to protect the public. There should be provision in the Act for an Ambulance Officers Registration Board consistent with the Victorian model for the registration of health practitioners.

Conclusions and Recommendations

There is a continuing need for provisions that limit the use of the term 'ambulance'.

The right to use the term ambulance should be part of licensing/registration systems for providers and their employees as described in the preferred model. Provisions to support such a system would need to be incorporated into the Act.

Regulations (Part 9)

Description

Part 9 of the Act (ie, section 40) provides wide–ranging powers for the Government to make regulations in support of the Act. This includes making regulations with respect to the qualifications of ambulance officers.

Issues

Regulations generally provide greater flexibility for governments — in particular, by addressing issues of detail not suited to an Act, or coping with unanticipated events without having to go through the process of amending an Act. Clearly, regulations under the Act could restrict competition.

These regulation–making powers have never actually been used; however, this is probably explained by the wide ranging nature of the other powers already provided under the Act. This may not necessarily be the case under a competitive model. If the provider is separate to the regulator/purchaser, then the ability to make regulations may well be an important and flexible power for the regulator/purchaser, particularly in an uncertain environment. Ideally, the areas in which regulations can be made, and by whom, would need to be well defined.

Conclusions and Recommendations

Power to make regulations will be required under the Act in support of the roles identified under the preferred model.

Transitional Provision, Amendments and Repeals (Part 10)

Description

Part 10 provides for:

- A range of transitional provisions relevant to introduction of the Act in 1987 (s.41 and s.42).
- Provisions concerning investment and borrowing by ambulance services (s.43 and s.44).

Conclusions and Recommendations

There are no competition issues concerning the transitional provisions, although transitional arrangements would be required in the establishment of the new legislative framework.

Controls on investment and borrowing by ambulance services form part of the governance and accountability structures of providers. These issues and alternatives on these broad issues have been addressed in previous sections of this report.

6.2 Other Relevant Legislation

Road Safety

Description

Provisions of the Road Safety Act 1986 and the Road Safety (Traffic) Regulations 1988 that are relevant to Ambulance Services were described in Section 2.4 of this report. They largely relate to the fitting of lights and sirens, the ability to act as an emergency vehicle in traffic, and registration issues.

Conclusions and Recommendations

As discussed earlier, these provisions constitute an important restriction on entry to the emergency response market. At the same time, being able to act as an emergency vehicle in traffic is a right that should not be granted lightly and would need to be carefully regulated. This would be handled principally through the proposed registration/licensing system and may not require any change to the Road Safety Act.

Drug Control

Description

The provisions of the Drugs, Poisons and Controlled Substances Act 1991 and Drugs, Poisons and Controlled Substances Regulations 1991 that are relevant to ambulance services were described in Section 2.4 of this report. They largely relate to necessary authorisation for the possession and administration of drugs.

Conclusions and Recommendations

As discussed earlier, these provisions do not constitute a major restriction on entry to the emergency response market since private providers are free to seek the same medical authorisations under the legislation as government providers.

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